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THE AMERICAN INDIAN ELDERLY: THE FORGOTTEN POPULATION

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

SECOND SESSION

PINE RIDGE, SD

JULY 21, 1988

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CONTENTS

Page

Opening statement by Senator Larry Pressler, presiding 1

CHRONOLOGICAL LIST OF WITNESSES

David Merwin, acting administrator, Bennett County Hospital, Martin, SD 5
Francis Swift Bird, director, Felix S. Cohen Home, Pine Ridge, SD 15
Geraldine Janis, director, Oglala Sioux Tribe's Community Health Representative Program, Pine Ridge Reservation, SD 16
Iyonne Garreau, director, Sioux Nation Commission on Aging 23
Elaine Quiver, director, Foster Grandparent Program, Pine Ridge, SD 25
Frank Marshall, Fifth Member, Oglala Sioux Tribe 30
Chief Oliver Red Cloud, chairman, Eight Reservation of Old People 31
Vernon Ashley, Pierre, SD, past State program director, ACTION 32
Royal Bull Bear, Kyle, SD 40
Marie Randall, Wanblee, SD 47
Cecelia Montgomery, Wa Wo Kiye Os-piyea Elderly Program, Rapid City, SD 53

APPENDIX

WRITTEN TESTIMONY PERTAINING TO HEARING

Item 1. Statement of the National Association for Home Care 57
Item 2. Testimony of the California Indian Council on Aging, submitted by Patrick Renick, program director 59
Item 3. Testimony of the National Indian Court Clerks Association, submitted by Jane M. Smith, president 61
Item 4. Testimony of the National Title VI Grantees Association, submitted by Steve R. Wilson, chairman 65
Item 5. Testimony of the Oklahoma Indian Council on Aging, submitted by Steve R. Wilson, chairman 80
Item 6. Statement of the National Indian Council on Aging, submitted by Curtis D. Cook, executive director 86
Item 7. Statement of the Indian Health Service, DHHS, submitted by Dr. Everett R. Rhoades, Director 92
Item 8. Statement of the South Dakota Department of Social Services/Adult Services and Aging, submitted by James West, social worker 96
Item 9. Statement of the American College of Health Care Administrators, submitted by Richard L. Thorpe, executive vice president 98
Item 10. Statement of the National Center for American Indian and Alaska Native Mental Health Research, submitted by Spero M. Manson, associate professor and director 103
Item 11. Statement of the Arizona Long Term Care Gerontology Center, submitted by Theodore H. Koff, Ed.D. and Kristine Bursac, M.P.A 107
Item 12. Statement of the Idaho Indian Council on Aging, submitted by Hugh Edmo, chairman 113
Item 13. Statement of the National Senior Citizens Law Center, prepared by Alfred J. Chiplin, Jr., Esq. with Donna Shea, law clerk 115
Item 14. Statement of the Federal Council on the Aging 118
Item 15. Statement of the Yankton Sioux Elderly Case Management Services, submitted by Darrell E. Drapeau, elderly case management supervisor 121
Item 16. Statement of the U.S. Administration on Aging, submitted by Carol Fraser Fisk, Commissioner on Aging 125

Page

Item 17. Statement of the National American Indian Housing Council, submitted by Virginia E. Spencer, executive director 129
Item 18. Statement of the U.S. Equal Employment Opportunity Commission, submitted by Tony Gallegos, chairman, Tribal Employment Rights Offices Program 133
Item 19. Statement of the U.S. Department of Housing and Urban Development 149
Item 20. Statement of the Indian Health Service, DHHS, submitted by Allen W. Jones, Jr., M.D 153
Item 21. Statement of the Bureau of Indian Affairs, Department of the Interior 155
Item 22. Statement of the National Indian Health Board, submitted by Jake L. Whitecrow, executive director 159

THE AMERICAN INDIAN ELDERLY: THE FORGOTTEN POPULATION

THURSDAY, JULY 21, 1988

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Pine Ridge, SD.

The committee met, pursuant to notice, in Pine Ridge, SD, Senator Larry Pressler presiding.

Present: Senator Pressler.

Staff present: Herb Weiss.

WELCOMING STATEMENT BY MR. MEANS

Mr. MEANS. Well, good morning. And I just can't thank the Senator enough for coming down our way and showing his concern. We just got finished taking a tour, looking at various sites concerning the Mni Wicone Water Project; and I think the Senator is going to talk a little bit on that.

The presentation is ready to start, so I'll turn it over to the Senator. Thank you.

OPENING STATEMENT BY SENATOR LARRY PRESSLER

Mr. PRESSLER. Thank you very much. Let's move closer together. This isn't church, so you can sit in the front row. Can you hear me clearly?

Thank you for being here. I also want to thank your leader for the good job he did this morning on the tour describing the water project;

Also, Elaine Quiver, the Director of the Foster Grandparent Program on the reservation, who has done so much to help organize this hearing.

This is an official Senate Special Committee on Aging hearing, and a record of this meeting will be kept. I believe it's the only hearing to focus on the specific problems of the Indian elderly this year.

Before we get into the testimony, I want to bring you up to date on the status of the water pipeline project. We are working very hard to get this project authorized and funds appropriated.

We must pass both an authorization and an appropriation bill to fund the project. The authorization bill has passed the House. I will continue to work closely with my Senate colleagues and the Governor's office to make this project a reality.

This morning I saw some of the worst water conditions in the United States. People have to haul water long distances to obtain

safe drinking water. The Oglala Reservoir is very polluted. At one time, children could swim there. However, if they now swim in the lake, they develop a rash.

At one point the reservoir had good edible fish. But now I'm told the fish have parasites and can't be eaten. This is in part because a pump on White Clay Creek doesn't work properly. That's a separate problem. My staff will be working with tribal leaders and State officials to do something about that problem.

Water samples were taken this morning out of the Reservoir and I shall review the results when they're tested in Pierre. I've already been told the water is so polluted you can't swim, fish, or drink it. It seemed ironic to me that with such pure people and clear air as we have here, that we should have such polluted water.

I was told about the problems of well-drilling in the area. The shallow wells of 140 feet frequently have alkali. Deep wells that would reach down into the Madison Formation are very expensive. We have a real problem in terms of drinking water, a basic human need. We talk about people's rights and problems. We talk about problems of the elderly. But it is a hard realization that elderly people must haul water. This is a terrible problem.

I remember many years ago a meeting in Chamberlain where I drew in longhand a pipeline to serve western South Dakota. I've been working on it since. Long before that meeting, I introduced the first legislation for the WEB Water Pipeline in north central South Dakota. The WEB project is nearing completion and is bringing clean drinking water to farms and homes.

We drove by the Pine Ridge—the ridge for which Pine Ridge is named—which is very much in need of reforestation. We have reforestation programs in our foreign aid program. It seems our own people and our own citizens sometimes don't enjoy these same benefits. That's something we need to work on.

There were many other subjects discussed this morning, housing for instance, one of the concerns with which your fine leaders must deal. I have two people on my staff who deal almost exclusively with Indian problems. Over the years, I have made it a priority to visit Indian reservations in South Dakota and I will continue to do so.

The purpose of today's hearing is to examine the unique problem of the American Indian elderly. Are they different from any other population group? Do the Indian elderly utilize nursing homes more or less than other population groups? Do they have unique problems?

Of course, both young and old American Indians have a multitude of problems to resolve. Problems found on reservations affect all age groups, young and old alike. The water problems I mentioned before are a major problem for the elderly.

Let's now turn our attention to this field hearing of the Senate Special Committee on Aging. Senator Melcher of Montana, Chairman of the Committee, authorized this hearing. I want to thank him for his support of my desire to pay special attention to the needs of American Indian elderly. I want to thank the experts who are appearing as witnesses.

Again, I would like to recognize Elaine Quiver and her Foster Grandparent Program. Programs like the Foster Grandparent Pro-

gram provide opportunities to preserve traditional values and culture through building communication between older and younger generations. Isolation between the Indian elderly and the rest of the tribal community can be reduced through this type of program.

It is my belief that older American Indians are a forgotten minority. They are one of the most impoverished groups in the United States. Numbering 109,000 in 1980, older Indians comprise only 8 percent of the total Indian and Alaskan population. Although the number of older Indians is expected to reach 200,000 by the year 1990, this group still represents only a small portion of the total elderly population in the United States.

Their numbers may be small when compared to the total older population, but the needs of older Indians are far greater. Many American Indian elderly are born, live, and die in an environment of poverty. According to the 1980 census, 61 percent of these individuals had incomes below the national poverty level. From Indian reservations to cities, these individuals often live their last years deprived of a decent standard of living.

The American Indian elderly can barely purchase the basic necessities of life. Many of these individuals were not employed in their younger years because of limited education and job opportunities. The majority of these individuals will not receive a monthly Social Security or pension check because of their limited work history. Because of their lower life expectancy, the Indian elderly are not likely to live long enough to become eligible to participate in Federal entitlement programs.

The American dream of having the opportunity to live in safe, well-constructed housing is out of reach to many American Indian elderly. They have lived a lifetime in dilapidated, crowded housing. A 1980 survey by the National Indian Council on Aging found that 26 percent of elderly Indians lived in homes constructed before 1939. Twenty-five percent of the respondents reported that they used outdoor toilets; 24 percent had no indoor plumbing; 42 percent had one to four broken windows; and 35 percent had broken doors; and 75 percent did not have telephones to use in case of an emergency. Many of their homes still do not have electricity.

Lack of plumbing and running water has contributed to the widespread prevalence of tuberculosis among the Indian elderly. According to the National Indian Council on Aging, the rate of tuberculosis is five times higher among this group than among the general elderly population.

A lifetime of poor health has drastically reduced the life expectancy of the American Indian elderly. According to the 1980 census, the life expectancy of the older Indian is 63.1 years compared to 71 years for the non-Indian older population. I think that's a very significant difference—nearly an 8-year difference. Diabetes, liver and kidney disease, cataracts, rheumatoid arthritis, and heart disease reduce their quality of life. Their poor nutrition adds to their existing health problems.

The very limited number of studies provide us with a glimpse of mental health problems of the American Indian elderly. These studies seem to indicate that these individuals suffer from clinically significant levels of depression and high levels of anxiety because of their health problems.

The increasing mobility of the Indian population has led to older Indians becoming more isolated from their families. Many experienced a diminished role in their families. Increased alcoholism of younger Indians has led to neglect and abuse of older Indians.

Today, many barriers reduce access to health care, both on reservations and in cities. Lack of transportation on remote reservations often results in older Indians being unable to attend multipurpose senior centers. In some cases, these centers are not located on reservations. Thus, older Indians are deprived of social opportunities, nutritious meals, and a place to participate in fulfilling activities.

In urban areas, the Indian elderly cannot utilize health care services provided by tribal governments or by the Indian Health Service. Limited knowledge of available health care resources, combined with the fear of using public transportation, keep many of these individuals from seeking medical care in cities, even when it is needed.

With multiple chronic conditions that are often debilitating, many American Indian elderly require nursing home care. Only nine nursing homes are located on tribal lands in five States. Individuals who require intensive nursing care are placed in nursing homes located off the reservation. In South Dakota, 22 Indian elderly have been placed at the Bennett County Nursing Home, located 52 miles from the Pine Ridge Reservation. Distance and inadequate transportation can isolate them in an unknown environment away from their families, friends, and tribal communities.

Most American Indian elderly wish to remain independent and in their reservation homes. The Community Health Representatives program on Pine Ridge Reservation provides home health care and personal care services to elderly Indians in their homes. Because of limited funding, this program cannot reach all of those in need of such assistance.

Let me conclude by saying that many advocates for older Indians are very concerned about the inadequate level of funding for Title VI of the Older Americans Act. This legislation provides tribal governments with direct funding for nutrition and supportive services. Since 1980, the amount of funds appropriated for this program has increased by only 25 percent, compared to 75 percent for Title III, Parts C1 and C2, which provide funding for congregate and home-delivered meals.

Because of the inadequate funding of Title VI, nutrition sites on reservations have been forced to reduce staff, serve fewer elderly, or reduce the number of meals they serve per week. According to NICOA, only one-fourth of the 504 Indian tribes receive Title VI grants. They are able to serve an average of only 50 percent of the eligible elderly.

As a member of the Senate Aging Committee, I believe it is important to examine the special needs of the American Indian elderly. I hope that our hearing today will shed more light on better approaches to providing a decent life for American Indian senior citizens.

This concludes my opening statement. I would like now to call on our first witness. I shall request our witnesses to limit their oral statements to about 5 minutes. We will put their entire statements

in the record. It would be very helpful if you could summarize your remarks.

Our first witness will be David Merwin of the Bennett County Nursing Home in Martin SD. He will discuss the use of nursing homes by the American Indian elderly. I thank you for being here.

TESTIMONY OF DAVID MERWIN, ACTING ADMINISTRATOR, BENNETT COUNTY HOSPITAL, MARTIN, SD

Mr. MERWIN. I'm the acting administrator of Bennett County Hospital in Martin, SD, and we also have the nursing home connected with the hospital. I would like to testify at this time about the Indians in our nursing home.

The Bennett County Nursing Home is located at Martin. It's been operating since 1983. It was constructed in—it began construction in 1982. The project was spearheaded by a group of concerned citizens of Bennett County who wanted such a facility built in the county for the elderly. This concern led the voters of Bennett County to the primary election polls June of 1980. Eighty-five percent of the people at that time asked for a nursing home at Martin.

The concern of the citizens became a reality when the doors were opened in 1983. The home opened to natives of Bennett County who were, at that time, placed elsewhere in nursing homes. Now they could come home. This is exactly what they did when the nursing home in Martin opened. Many of the residents placed elsewhere, such as Gordon, NE; Kadoka, White River, and Rapid City, came home to live in their own nursing home in Martin. Many of the residents who returned to the Martin area were Indian elderly also. They wanted to be moved closer to their home, which is the Pine Ridge Indian Reservation.

Bennett County Nursing Home is a 50-bed facility and provides two levels of nursing care; skilled and intermediate. Skilled nursing care provides more intensive care of the resident. Of the 50 beds, 8 are for skilled care and 42 for intermediate care. The Bennett County Nursing Home is about 45 miles east of the Pine Ridge Agency headquarters and 45 miles west of the Rosebud Agency headquarters. The community of Martin is about the midpoint of the two Indian reservations.

From the opening date of the nursing home in September 1983, the majority of the residents in the home have also been—or have always been at least two-thirds Indian. The census of the nursing home on July 13 of this year shows a number of residents, 41 total, of which 27 are native American or Indian, and 14 non-Indian residents. Of the 27 Indian residents, 5 are from Rosebud Indian Reservation, the remainder from the Pine Ridge Indian Reservation. Of the 22 Pine Ridge Indian Reservation residents, two are private pay. That means they're responsible for their own expenses while in the nursing home. Of the 14 non-Indian residents, 3 are private pay. The remainder of the residents, or 36, are assisted by the State of South Dakota Title 19 program for long term care. Without the State assistance, most of our Indian elderly and non-Indian elderly would not be able to live in a nursing home.

The services provided by the Bennett County Nursing Home include: 24-hour-a-day professional nursing care, a physician who is a

specialist in geriatrics, an activities program coordinator, and a social service program coordinator.

The staff of the Bennett County Nursing Home includes 3 native American LPN's out of 4 total, 8 Native American nurses aides out of 16, and 1 Native American social service coordinator in an office of 1. This does not include the other departments in the home. These Native American employees are bilingual and are able to bridge the communication problems experienced by the non-Indian employee. A communications handbook has been established for the non-Indian employee. A communications handbook has been established for the non-Indian employees to aid them in communicating with the elderly Indian.

The majority of the non-Indian residents are natives of Bennett County and are comfortable being where they are surrounded by their relatives and friends. Whereas, the Pine Ridge and Rosebud elderly do not feel at home at Martin as the transition of moving off the reservation to the Martin Nursing Home deeply affects them. Although Martin is very close to the Pine Ridge and Rosebud Reservation, they feel it is a non-Indian community and they do not belong there, but would rather be "home" on the reservation. The Indian elderly in the home come from seven of the nine Pine Ridge Reservation districts. The five Rosebud residents come from four of the Rosebud communities.

The referral to the Martin Nursing Home of the Indian resident is usually made by the Department of Adult Services and Aging in Pine Ridge or the medical social worker at the Pine Ridge Public Health Service Hospital. These referrals are made due to the medical condition of the resident and the inability of the family to provide the proper medical care needed in a home setting.

Admitting a family member to the nursing home is a difficult ordeal for the non-Indian and the Indian; more so for the Indian resident. Adjustment to the nursing home is more difficult for the Indian as the nursing home environment is a greater change from the environment they are accustomed to in their previous entire life; whereas, the non-Indian resident and their families are more familiar with a nursing home setting and its purpose. These non-Indian families may have supported the building of the nursing home in their community knowing the need was there, whereas the Indian population may have had no previous knowledge of a nursing home and its purpose.

The Indian resident's biggest change is food and diet. During their entire 65 to 70 years they may have never been on a diet, nor have they eaten certain foods that may be a favorite of the non-Indian, such as pizza, sloppy joes, cauliflower, broccoli, Chinese vegetable blends, barbecue sauce, and Mexican foods. Some of their favorite foods are soup and hot biscuits. They could eat that several times a day or all three meals and be happy with it. They like fried potatoes with onions, tripe with dried corn and wild turnips, wild berry pudding, and fry bread. With the Indian elderly, the change is extremely difficult. Although they eat their meals in the nursing home, they often speak of the hunger for their traditional foods.

Diets to the Native American are contradictory to their culture as a thin Indian is considered to be poor or ill. Non-Indian lady residents like to have their hair cut and styled, while the Indian

lady residents not only dislike this but consider it contradictory to their cultural beliefs. Indians do not cut their hair unless there is death in the immediate family. Cutting their hair is a sign of mourning.

Due to the overall economic problems of the Indian residents find it difficult to visit the nursing home as often as they wish. The problems expressed by the families is that they do not have the transportation nor the finances to travel to Martin. Whereas, the non-Indian resident is visited frequently by their family due to the fact that they live in the immediate area of the nursing home.

Although many of the non-Indians visit the Indian residents, they tend to shy away from them and are usually afraid to speak to them due to their poor English-speaking ability and recognized differences in culture.

I'd like to point out some of the activities offered by the Bennett County Nursing Home of the Native American residents and maybe could be used in the development of other nursing homes for the Indian elderly: We introduce them to friends and relatives already in the nursing home and assure them that they are not alone.

We assure them immediately that there are Native American staff members who can and will assist them in the area—in any area possible. That their concerns, their needs, and their problems will be addressed by these staff members to the non-Indian staff for solving.

Social service coordinator, which is a Native American, correlates with the activities director, a non-Indian or a non-Native American. They coordinate activities that the Indian elderly are accustomed to. These activities include mini-powwows at the nursing home at which time families and friends are invited. This activity includes the non-Indians who wish to participate, and the majority of them do

The social service coordinator assists the elderly Indian ladies in making shawls and making headdresses with beads.

They encourage their gathering to listen to Indian music together and reminisce. This is a great inspiration to the Indian elderly.

We provide transportation to the respective reservation hosptials for eye appointments and occasional checkups. These checkups at these hospitals are not necessary—are not necessary as the Martin clinic is located in the same building as the Bennett County Hospitial. However, an occasional trip is made to give the residents the opportunity to visit their hospital and doctor. The eye appointments are necessary to obtain assistance through the tribal elderly programs to purchase the eyeglasses for the Indian residents. Should a referral be made to the PHS eye doctor, they provide financial assistance for the Indian elderly, should it be needed. This is not available at Martin.

The dietary department of the nursing home prepare special meals for the Indian resident. This consists of beef stew, fry bread and Indian pudding, usually made of wild berries, however, the dietary department substitutes other fruit when wild berries are not available.

During the past two summer months, some of the Native American staff members have provided wild berries and turnips to the

Indian elderly of the home. They comment that eating these foods revives them, and it's encouragement for them to go on living for a period of time. However, they believe that they are slowly starving to death because they are not able to eat their own traditional foods on a regular basis.

Indian elderly placed in nursing homes off the reservations need more understanding from the non-Indian staff. The non-Indian staff must be willing to listen and understand the elderly Indian. Provisions must be made to meet their unique and special needs in order that they may be happy in their last years of their life. These people have come a long way in life and deserve to retain their own traditional values to the end. These are objectives that we are currently working on.

There's many supporters of our facility at Bennett County. They're the Kyle Senior Citizens Groups at Kyle. Mr. Chissoe Gray, a mental health worker at Pine Ridge Hospital. The H.E.W. Committee of the Oglala Sioux Tribal Council, and Judge Etta Youngman of the Tribal Courts, Pine Ridge.

A nursing home built in the Indian reservation would be a better place for the elderly Indian. They would be much happier knowing they are at "home" and that they have their families, especially their children, the grandchildren—they are very closely bonded with their grandchildren—friends, relatives, and homes around them.

Communication with reservation news and events is by listening to one of the two radio stations and the Lakota Times newspaper.

We conclude our testimony on the elderly Indian at the Bennett County Nursing Home, and we thank you for this opportunity. Thank.

Senator PRESSLER. Thank you very much for that moving description of some of the differences in diet and living conditions. I really appreciate your testimony.

I would like to ask one question. Since it's over 50 miles from the Pine Ridge Reservation, do family members, friends, or other tribal members visit more often than normal? Would that be the case, or would they visit less often?

Mr. MERWIN. Very much less. Distance has a bigger factor to the Indian than the non-Indians in our area. And statistics show in our facility that the Indians have family members visiting much less than the non-Indian, who live—who are closer to home.

[The prepared statement of David Merwin follows:]

BENNETT CO. HOSPITAL & NH
BOX 70-D
MARTIN, SD 57551

07-15-88

SENATOR LARRY PRESSLER
UNITED STATES SENATE
WASHINGTON, DC 20510

Dear Senator L. Pressler,

The following testimony is in response to your letter of invitation dated July 8, 1988. I thank you for the opportunity to offer this presentation on behalf of the Bennett County Nursing Home.

The Bennett County Nursing Home is located in Martin, South Dakota and has been in operation since September 1, 1983. The construction of the facility was begun in October, 1982, and was built adjacent to the Bennett County Community Hospital. This project was spearheaded by a group of concerned citizens of Bennett County who wanted such a facility built in the county for their elderly. This concern led the voters of Bennett County to the primary election polls on June 3, 1980, at which time 85% of the voters gave their approval on the building of a Nursing Home in Martin. The concern of the citizens became a reality when the doors of the Bennett County Nursing Home opened to natives of Bennett County who were, at that time, placed elsewhere in Nursing Homes. Now, they could come home! This is exactly what they did when the Nursing Home in Martin opened. Many of the residents placed elsewhere, such as Gordon, NE, Kadoka, White River and Rapid City, came home to live in their own Nursing Home in Martin. Many of these residents who returned to the Martin area were Indian elderly and non-elderly who wanted to be moved closer to their home which was the Pine Ridge Indian Reservation.

Bennett County Nursing Home is a 50 bed facility and provides two levels of nursing care: skilled and intermediate. Skilled nursing care provides more intensive care of the resident. Of the 50 beds, 8 are for skilled care and 42 for intermediate care.

The Bennett County Nursing Home is approximately 45 miles east of the Pine Ridge Agency headquarters and an estimated 45 miles west of the Rosebud Agency headquarters. The community of Martin is about the mid-point of the two Indian Reservations. In fact, the community of Martin is adjacent to the Pine Ridge Indian Reservation.

From the opening date of the Nursing Home in September of 1983, the majority of the residents in the home has always been at least two thirds Native American. The census of the Nursing Home on July 13, 1988, shows a number of 41 residents of which 27 are Native American and 14 non-Indian residents. Of the 27 Indian residents, 5 are from the Rosebud Indian Reservation and the remainder from the Pine Ridge Indian Reservation. Of the 22 Pine Ridge Indian Reservation residents, two are private pay (they are responsible for their own expenses while in the NH). Of the 14 non-Indian residents, 3 are private pay. The remainder of the residents (36) are assisted by the State of South Dakota Title 19 program for Long Term Care. Without the State assistance, most of our elderly, both Indian and non-Indian, would not be able to live in a Nursing Home.

The services provided by the Bennett County Nursing Home include; 1) 24 hour professional nursing care; 2) Physician (Specialist in Geriatrics); 3) Activities programs and 4) Social Service programs.

The staff of the Bennett County Nursing Home includes 3 native american LPN's out of 4, 8 native american Nurse's Aides out of 16, and 1 native american Social Service Coordinator office of 1. This does not include the other departments in the Home. These Native American employees are bilingual and are able to bridge the communication problems experienced by the non-Indian employee. A communications handbook has been established for the non-Indian employee to aide them in communicating with the elderly Indian.

The majority of the non-indian residents are natives of Bennett County and are comfortable being where they are surrounded by their relatives and friends. Whereas, the Pine Ridge and Rosebud Indian elderly do not feel at home at Martin as the transition of moving off the Reservation to the Martin Nursing Home deeply affects them. Although Martin is very close to the Pine Ridge and Rosebud Reservation, they feel that it is a non-Indian community and they do

not belong here but would rather be "home" on the Reservation. The Indian elderly in the Home come from seven of the nine Pine Ridge Reservation districts. The five Rosebud residents come from four of the Rosebud Communities.

The referral to the Martin Nursing Home of the Indian resident is usually made by the Department of Adult Services and Aging in Pine Ridge or the Medical Social Worker at the Pine Ridge Public Health Service Hospital. These referrals are made due to the medical condition of the resident and the inability of the family to provide the proper medical care needed in a home setting. Admitting a family member to the Nursing Home is a difficult ordeal for the non-Indian and the Indian. More so for the Indian resident. Adjustment to the Nursing Home is more difficult for the Indian as the Nursing Home enviroment is a greater change from the environment they are accustomed to in their previous entire life. Whereas, the non-Indian resident and their families are more familiar with a Nursing Home setting and its purpose. These non-Indian families may have supported the building of the Nursing Home in their communit, knowing the need whereas the Indian population may have had no previous knowledge of a Nursing Home and it urpose.

The Indian residents biggest change is food and diet. During their entire 70 years +, they may have never been on a diet nor have they eaten certain foods that may be a favorite of the non-Indian ie. pizza, sloppy joes, cauliflower, broccoli, chinese vegtable blends, barbeque sauce and mexican food. Some of their favorite foods are soup and hot biscuits(some could eat this three times a day and be happier than a pig in mud), fried potatoes with unions, tripe with dried corn and wild turnups, wild berry pudding and fry bread. With the Indian elderly, the change is extremely difficult. Although they eat their meals in the nursing home, they often speak of the hunger for their traditional foods. Diets to the Native American is contradictory to their culture as a thin Indian is either considerded to be poor or ill.

Non-Indian lady residents like to have their hair cut and styled while the Indian lady residents do not only dislike this but is again contradictory to their cultural beliefs. Indians do not cut their hair unless their is a death in the immediate family. Cutting their hair is a sign of mourning.

Due to the overall economic problems on the Indian Reservations, the families of the Indian residents find it difficult to visit the Nursing Home as often as they wish. The problems expressed by the families is that they do not have the transportation nor the finances to travel to Martin. Whereas, the non-Indian resident is visited frequently by their family due to the fact that they live in the immediate area of the Nursing Home.

Although, many of the non-Indians visit the Indian residents, they tend to shy away from them and are usually afraid to speak to them due to their poor English speaking ability and recognized differences in culture.

Some of the activities and services offered by the Bennett County Nursing Home to its Native American residents are;

1) Introduce them to friends/relatives already in the Nursing Home and assure them that they are not alone.
2) Assure them immediately that there are Native American staff members who can and will assist them in all areas possible. That their concerns/needs/ problems will be addressed by these staff members to the non-Indian staff for solving.
3) Social Service Coordinator (Native American) correlates with the Activitie Director (Non-Indian) activities that the Indian elderly are accustomed to. These activities include; mini-powwows at the Nursing Home at which time families and friends are invited, (this activity includes the non-Indians who wish to participate, majority of them do);
4) Social Service Coordinator assists the elderly Indian ladies in making shawls and making headdresses with beads.
5) Encourage their gathering to listen to Indian music together and reminisce. This is the greatest inspiration to them.
6) Provide transportation to their respective Reservation hospitals for eye appointments and occasional check-ups. The check-ups at these hospitals are not necessary as the Martin Clinic is located in the same building as the Bennett County Hospital. However, an occasional trip is made to give the resident the opportunity to visit their hospital and doctor. The eye appointments are necessary to obtain assistance through the Tribal Elderly Programs to purchase the eyeglasses for the Indian residents. Should a referral be made by the PHS Eye Doctor, they provide financial assistance for the Indian

elderly, should it be needed. This not available at Martin.
7) The dietary department of the Nursing Home prepare special meals for the Indian resident. This consists of beef stew, fry bread and Indian pudding (usually made of wild berries, however, the dietary department substitutes other fruit for the wild berries).

During the past two summer months, some of the Native American staff members have provided wild berries and turnips to the Indian elderly of the Home. They comment that eating these foods is a revival to them and can go on living for a period of time. However, they believe that they are slowly starving to death because they are not able to eat their own traditional foods on a regular basis.

Indian elderly placed in Nursing Homes off the Reservations need more understanding from the non-Indian staff. The non-Indian staff must be willing to listen and understand the elderly Indian. Provisions must be made to meet their unique and special needs in order that they may be happy in their last years of life. These people have come a long way in life and deserve to retain their own traditional values to the end.

The primary supporters of the Indian residents of Bennett County Nursing Home are:
1) Kyle Senior Citizens Group, Kyle, SD (Kyle is one of the nine districts on Pine Ridge Indian Reservation). This group of elderly Indians visit the Nursing Home on a monthly basis. They spend an entire afternoon at the Home visiting, playing bingo with the residents or sometimes have a meal with them. They occasionally bring a drum and the elderly men would sing for the residents. This group also brought Christmas gifts to all the residents (Indian and Non-Indian) for the past two years.
2) Mr. Chissoe Gray, (Native American) Mental Health Worker, Pine Ridge Hospital. Mr. Gray has visited the Nursing Home on a weekly basis for the past one and a half years. He visits with the Indian residents and provides the support needed by them. His visits are very encouraging.

3) H.E.W. Committee of the Oglala Sioux Tribal Council, during his term of Chairman of this committee, Mr. G. Wayne Tapio brought this group of Council Representatives to the Nursing Home to bring gifts to all (Indian and Non-Indian) residents of the Nursing Home and to

provide a Christmas program for them. This has been in the past two years. They also participated in Indian Family Day held during National Hospital and Nursing Home week in May of 1987. At that time, they donated funds to the Nursing Home to purchase materials for the Indian elderly to utilize in making projects while in the Nursing Home.

4) Judge Etta Youngman, Oglala Sioux Tribal Courts, Pine Ridge

Judge Youngman is aware of the elderly needs on the Pine Ridge Reservation and assists in all ways possible to ensure that their needs are met. She trusts the professional staff of the Nursing Home to provide the needed medical care for the elderly Indian.

Overall, more support from the Tribal governments and entities are needed by the elderly Indian residents in Nursing Homes.

A Nursing Home built on the Indian Reservation would be the better place for the elderly Indian. They would be much happier knowing that they are at "home" and that they have their families (especially grandchildren, they are very closely bonded with their grandchildren), friends, relatives and homes around them.

Communications with Reservation news and events is by listening to one of the two radio stations. One radio station (KINI) is located on the Rosebud Indian Reservation and the Rosebud residents prefer listening to this station. The other radio station is KILI located on the Pine Ridge Indian Reservation of which the Pine Ridge residents listen. For those who are able to read, they enjoy the Lakota Times, which tells of any Indian news and happenings.

This will conclude this testimony on the elderly Indian at the Bennett County Nursing Home in Martin, SD.

Thank you for the opportunity to make this presentation.

Sincerely,

David Merwin

David Merwin, Administrator

Colene Hemminger

Colene Hemminger, Social Service Coordinator

Senator PRESSLER. Well, I want to salute you because you're doing good work.

My father is in a nursing home over at Salem, SD. He has Alzheimer's disease. I would like to recognize the dedication of health care professionals in South Dakota and across our nation. I think you're a good example of their professionalism, Dave. I can tell by listening to you how dedicated you are to your patients. We're lucky to have such a person as you working in South Dakota.

Let me next call Francis Swift Bird, manager of the Felix S. Cohen Home in Pine Ridge, SD.

TESTIMONY OF FRANCIS SWIFT BIRD, DIRECTOR, FELIX S. COHEN HOME, PINE RIDGE, SD

Mr. SWIFT BIRD. I'm Francis Swift Bird, present director of Felix S. Cohen Home in Pine Ridge, South Dakota.

The Cohen Home opened in 1964. It is equipped to serve approximately 44 people. Currently 22 people reside there, and it has had as many as 30 people living there. It is an independent living facility. It was set up to serve people 60 and over who are able to take care of themselves.

The Cohen Home was funded by H.U.D. They initially provided the home and food at that time. Later the food allotment was dropped by H.U.D. Food services now are funded by the Title VI program.

The operation of the home is funded by rental fees. The standard fee when it was opened was $124 a month for board and room. Welfare checks were $139 a month for most clients. Most residents had $9 to $15 spending money for the month. The rent is still $124 a month because no adjustment has been made to keep up with inflation. H.U.D. takes a percentage of the rent, and the home operates on what's left of the rental income. The month of July our rent was $2,422. The H.U.D. percentage was $1,801. Cohen Home takes $717.

The director and labor supervisor and head cook are tribal employees. All workers are referred by job services from various progams such as TWEEP, JTPA, WIN, or Green Thumb.

At this time we have two security guards, one Green Thumb working 24 hours a week; and the other security is JTPA, and he works 40 hours every month; one maintenance man I've had for 4 years now. I wish all our laborers were as good as he is. We don't have any problem with our labor. We got two housekeepers provided by JTPA; and four cooks, one head cook and the other three are WIN workers. What we need most now is six security guards, three maintenance men, three housekeepers, four cooks, three helpers. That would set our staff in full force. So we'd have a better security than what we have now.

Birthdays are recognized for each resident every month or maybe every other month. Churches provide a variety of services about four times a week. Lutheran churches from across the country donated supplies such as bedding, linen, and soap. The Lutheran Church in Estes Park, CO has been providing Christmas activities for about 12 years.

Our major problem, the roof has been leaking for the past 4 year. Now I think the money for repairing is about to be released most anytime. We're keeping our fingers crossed for that.

The water causes damages to most of our inside living quarters. Here in the past 3 weeks we had to move some of our tenants to dryer rooms. The Senator is talking about water shortages. We have a lot of water there and can pipe it out. One apartment was still running water after 10 hours after the rain we had on Sunday.

And my testimony of what I know ends there. So if there's any questions besides that, I'm willing to answer. Thank you.

Mr. PRESSLER. Thank you. I would like to ask one question. Since this is an official Senate Aging Committee hearing, I think people reading this record would be curious about your need for six security guards. What are the conditions or the problems that require your needing security guards?

Mr. SWIFT BIRD. We have a lot of problems in security. In case of sickness or any thing, we don't have no security during the night. And our—our staff sets up for 50,980 bucks for five laborers. But on account of financial limitations, there's only three of us. I, the director, and the labor supervisor and the head cook are the only three that work. And we have the full staff, to bring us down to $54,600. And that would get Cohen Home a security through the night taking care of the older people because they need security.

So they're there because they call that home, a home which they want safe. Because we have a lot of drinking problem here, and we've got a lot of visitors any hour of the night. And a lot of these tenants lose radios and stuff because they break in and stole stuff. So our security is our biggest problem.

And our cooks. Cooks go to powwows, and they don't leave the other cooks notice. Then we're a meal short sometimes. We have later meals. So that's it.

Mr. PRESSLER. Good. Thank you.

My staff member, Herbert Weiss, has given me an announcement from the Department of Housing and Urban Development (HUD) concerning a $122,000 grant recently approved by HUD to repair the leaky roof of the Felix S. Cohen Home. That's a very much needed improvement. This is very good news. Francis, I hope this emergency funding will help you solve one of your problems.

I next call on Geraldine Janis. She is the director of the Sioux Tribe's Community Health Representative Program of the Pine Ridge Reservation.

Geraldine, thank you for your testimony today and what you've done.

TESTIMONY OF GERALDINE JANIS, DIRECTOR, OGLALA SIOUX TRIBE'S COMMUNITY HEALTH REPRESENTATIVE PROGRAM, PINE RIDGE RESERVATION, SD

Ms. JANIS. Senator Pressler, I'm honored to have this opportunity to present testimony before your committee.

My name is Geraldine Janis. I'm the director of the Oglala Sioux Tribe's Community Health Representative Program of the Pine Ridge Indian reservation.

Since March 1965 a program for indigenous health workers was initiated on our reservation because it was obvious for a long period of time that health service to the Oglala, Lakota people has been inadequate reservation wide. I have worked with this program first as a team leader and then as the program director.

I feel honored to be here to present the views of the community Health Representatives and myself concerning the elderly clients we contact as part of our duties. There are Community Health Representatives assigned to each of the nine districts on the Pine Ridge Reservation.

The major purpose of the Community Health Representative Program is to assist Indian families in improving their overall health by providing preventative health education and services as well as treatment within the realm of their training.

The Community Health Representatives work in six categories of health areas. These are general health, dental health, gerontological health, maternal and child health, mental health, and environmental health care.

I will address the gerontological care category in reply to the information requested in the letter of invitation to this hearing.

I got my papers mixed up. Again I want to thank you. I will submit my written statement to the record. Thank you.

[The prepared statement of Geraldine Janis follows:]

PHONE (605) 867-5821

Community Health Representative
OGLALA SIOUX TRIBE
P. O. BOX A
PINE RIDGE, SOUTH DAKOTA 57770

July 14, 1988

Testimony of Geraldine Janis
Director Community Health Representative Program

"The American Indian Elderly: The Forgotten Population"

Before

Senate Special Committee on Aging United States Senate

My name is Geraldine Janis, I am the Director of the Oglala Sioux Tribe's Community Health Representative Program of the Pine Ridge Indian Reservation. Since March 1965 a program for indigenous health workers was initiated on our reservation because it was obvious for a long period of time that health service to our Oglala Lakota people has been inadequate reservation wide. I have worked with this program first as a Team Leader and then as the Program Director.

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I will address the Gerontological Care category and reply to the information requested in the letter of invitation to this hearing.

#1. Home Health Care and Personal Care Services Provided to Elderly Indain

Within the State Social Services Department there is a Home Health Aide Program whose main duties are to provide various in-home tasks for individuals needing assistance but unable to accomplish it themselves. They also transport elderly clients to meal sites. There are two (2) meals for the Elderly Programs serving the Elderly throughout the reservation. One is under Title VI and serves 627 meals from six (6) sites and Title III, serves Elderly at three (3) meal sites. Home Health Aides also transport their clients to hospitals and clinics where they utilize their medicare/medicaid and they also take them shopping for

groceries and clothing.

#2. Number of Elderly assisted through the Community Health Representative Program

There are approximately 1200 elderly throughout the reservation. In a six (6) month period 2073 visits were made by the Community Health Representatives to the elderly. Many of these visits were referred by the Community Health Nurses or Doctors or were on site homvisits because of the Community Halth Representatives concern for the elderly.

One of the Community Health Representatives in Pine Ridge takes care of the twenty two (22) elderly tenants at the Cohen Home on a daily basis for their health care needs. Some of these tenants have some type of disability but otherwise are able to help themselves. Cohen Home is not a nursing home. The Community Health Representative assists the tenants by checking their medication, picking up their refills, transporting them to clinic, helping them with their personal hygiene and other homenursing or first aid duties. These duties apply to the Community Health Representatives in the Districts also in caring for the elderly.

In many of the homes Community Health Representatives observed that many of the elderly need personal items or equipment but are unable to purchase them in many instances. They need equipment such as wheelchairs, walkers, crutches, canes, commodes, beds with waterproof mattresses also bedding, sheets, blankets, etc. The patients who are incontinent need personal items and require more care for their comfort. Community Health Representatives also observed the housing conditions that Elderly live in. A few homes are still substandard with no electricity or indoor running water. These homes are referred to Oglala Sioux Tribal Home Improvement Program or Indian Health Services Sanitation Department for the possibility of fixing indoor bathrooms for the elderly. Some were fortunate to have plumbing put in and an indoor bathroom while others are waiting because there are no funds for these projects. In other H.U.D. low housing projects some of the elderly have no electricity or heat because they are the sole providers of the household and cannot meet their payments for the electric bill. The reason that they are the sole providers is that the Grandmas or Grandpas are usually the landowners on which homes are build or they are the ones paying the rent out of their meager S.S.I. income. They usually take care of their children or grandchildren who live with them. In the winter time its sad to see the elderly suffer needlessly when their S.S.I. payments are stopped because they get their lease checks. They survive all year on S.S.I. and look forward to this lease check so that they can get a washing machine or fix their car if they have one or buy something they really need.

Community Health Representatives put the elderly on their priority of

services as well as little children. As indigenous people to our areas of employment we understand and remember why we were taught to respect our elders. They are the givers of wisdom and passed down the tradition and culture of our people. They taught us a respect for ways of the people, laughed with us when we struggled to interpret bilingually, and taught us many uses of Indian Medicine and how to detect certain illnesses.

#3. Can Community Health Representatives reach everyone who needs health services on the reservation?

So far Community Health Representatives have been reaching the people who need health services. They do out reach work throughout fifty three (53) communities within nine (9) political Districts of the reservation. Shannon County, which comprises most of the Pine Ridge Reservation, is concidered one of the poorest counties in the nation. Community Health Representatives see the evidence in the high unemployment rate (88%) and the socio-economic and geograhical isolation of the people. The Pine Ridge reservation covers a geographical area of 6,000 square miles. Community Health Representatives are limited to 1400 miles a month as set in their budget. Many of the people whom they visit lack knowledge of preventative health care and have no access to a health facility because of no transportation in many cases. In a six month period from July to December 1987, a total of 7808 people were transported and 4707 homevisits were made to 311 families. Many young and elderly people were transported to Pine Ridge Hospital because the District Clinics are unequipped with X-ray or Laboratory facilities. Some of the medication needed are not available at the District Clinic Pharmacies, or many people have appointments to specialists or have to be admitted. Community Health Representatives need to do more therapedtic work, monitor Indian elderly with chronic/acute conditions but transportation is a great need for the people. They have always been willing to work interdependently with other agencies and we have good rapport.

Community Health Representatives see many complications of Diabetes, such as vision loss or kidney failure among the elderly. There are five (5) elderly people on Kidney Dialysis at the Pine Ridge Unit. They need a bigger facility to adequately accomodiate all the patients.

#4. What assistance do Community Health Representatives receive from the Federal and State Government and the Tribe?

The Oglala Sioux Tribe Community Health Representative Program is funded from the Indian Health Service. The State supplies vaccine for Rabies Shots and also safety car seats for babies. The Oglala Sioux Tribe takes care of the accounting and bookkeeping for our Program.

#5. Is the Community Health Representative Program able to recruit nurses and aides?

The recruitment of personnel is done through the Oglala Sioux Tribe's Personnel board. The Community Health Representative Director is allowed to make recommendations in the final selection of staff. Four (4) Community Health Representatives presently are Emergency Medical Technicians, two (2) Community Health Representatives are Graduate Licensed Practical Nurses and the remainder have special training in various components of health care.

#6. What type of rehabilitation programs does the Community Health Representative Program offer?

The Community Health Representative Program does not offer any type of rehabilitation program. They work with other agencies in providing rehabilitation within the scope of their training.

#7. What happens when the elderly Indian can no longer stay at home?

As I had mentioned before, many of the homes were grandparent based. As children and grandchildren grew older they felt that grandparents were part of the nuclear family and accepted the fact that they were growing old and did not think of sending them away to Nursing Homes. When the elderly became helpless or ill the children and grandchildren had a deep concern for them and took their turn taking care of them. Today this still is true although times have changed. Of the 1200 elderly on our reservation twenty one (21) elderly people are at the Bennett County Nursing Home which is fifty two (52) miles away from Pine Ridge, South Dakota.

The State, Indian Health Services and Bureau of Indian Affairs Social Services and the Tribal Court usually make decisions in placement of elderly in Nursing Homes.

Most of the elderly are strong physically and mentally but when some get to the point of needing to go to a Nursing Home, they are reluctant because they don't want to be too far from their relatives. A Nursing Home or elderly housing complex is needed here at Pine Ridge. One that keeps the elderly close to their culture and traditions. Many of the elderly who belong to the Grey Eagle Society enjoy their meetings, activities, pow-wows, traditional feeds,

spiritual ceremonies and all participate with enthusiasm. They cannot be taken away from this because this is the life they know. When the elderly Indian can no longer stay at home it seems th t the circle of family unity is broken and that the elderly's spirit gets broken. He or she usually dies from loneliness in some Nursing Home in foreign surroundings.

36. How do Community Health Representatives interact with families?

A majority of the Community Health Representatives are very familiar with their geographical areas, families, and health problems and needs; therefore they have the confidence, respect, and trust of the people.

Community Health Representatives are present to take care of people health needs, to provide transportation, preventative health education and act as liaision between families and existing agencies for communication.

Mr. PRESSLER. Thank you very much, Geraldine. Next, we'll hear from Iyonne Garreau, who's driven a great distance to attend today's field hearing. I've talked to her numerous times over the years. She's the director of the Sioux Nation Commission on Aging. I know of your excellent work. Thank you very much for being here. We look forward to hearing your testimony.

TESTIMONY OF IYONNE GARREAU, DIRECTOR, SIOUX NATION COMMISSION ON AGING

Ms. GARREAU. In the spirit of unity and peace do I testify today on behalf of the elderly of the Sioux Nation. I wish to thank Senator Pressler for inviting me to share our concerns regarding our highly respected elders.

For those of you that I'm unfamiliar to, and that's very few, I am Iyonne Garreau. And I'm from Cheyenne River. I'm the chairperson for the Sioux Nation Commission on Aging. For 14 years I've served as a project director for the Cheyenne River Elderly Nutrition Services Program. So I've been involved with the elderly for a long time. Right now I have lost my mom and dad, my parents who I miss very much.

The Sioux Nation Commission on Aging was formed in 1986 to provide a forum for our elders to communicate their needs. The Commission is representative of 11 Sioux Tribes in South and North Dakota and Nebraska.

Our primary concern today is Title VI of the Older Americans Act. Although Title VI was established in the 1978 amendments to meet the unique needs and circumstances of American Indian elders on Indian reservations, adequate funding was never provided to carry out the intent of Congress. To date, 10 years later, Title VI is still underfunded.

It is true, the Indian elders are among the forgotten population, not by his own people, but by the Federal Government, which has a trust obligation not only to serve Indian tribes, but also to target services toward the vulnerable and needy among that population. No ethnic subgroup or age category better fits that description than the American Indian elderly. They are indeed among those in the greatest economic and social need.

I call to your attention the findings of Congress.

Section 611.(a) The Congress finds that the elder Indians of the United States, number 1 are a rapidly increasing population. Number 2, suffer from high unemployment. Number 3, live in poverty at a rate estimated to be as high as 61 percent. Number 4, have a life expectancy between 3 and 4 years less than the general population. Number 5, lack of sufficient nursing homes, other long-term facilities, and other health care facilities. Number 6, lack sufficient Indian areas agencies on aging. Number 7, frequently live in substandard and overcrowded housing. Number 8, receive less than adequate health care. Number 9, are served under this Title, that's Title VI, at a rate of less than 19 percent of the total national Indian elderly population living on Indian reservations. And number 10, are served under Title III at a rate less than 1 percent of the total participants under that Title.

I have seen the grandmothers and grandfathers of our people personally sacrifice their monthly pensions for the simple needs of their grandchildren because of an economic circumstance that plagues the Native Americans. I ask you, is this the kind of treatment that is bequeathed a legacy of a once proud spirited people?

The crisis worsens each day, and little help comes from a President who wants to "humor" the Natives.

I now refer to the 1987 amendments, our concerns per title.

Senator Pressler, do I have to read those or should I just——

Mr. PRESSLER. I have them here.

Ms. GARREAU. Okay.

Mr. PRESSLER. It might be good to highlight the titles.

Ms. GARREAU. Title I we have really identified none.

Title II we're talking about the 1987 amendments. This is law right now. We're having a problem implementing some of these things right now. Title 1, we asked for an Indian associate commissioner. We want this person to be Indian and fully empowered to act and implement remedial actions and programs.

Number 2, the Federal Council on Aging. We need to have an Indian representative on that board. This is what we ask.

Number 3, Inter-Agency Task Force. We need to include Indian tribes and non-Federal Aging organizations. Right now the Indian—or the Inter-Agency Task Force is being limited to Federal agencies. And we need people from the tribes, the people from the grass root level, people who have been working in the field with the Indian elders. We need those kinds of people at the top representing us. That's the only way we're going to get anything done.

Title III, we need our Title III and Title VI to get all these little service areas. We've got one goal in mind. We need to get out there and provide the money so that all the elders are served the way that's the intent of Congress. That's all we're asking is that everybody get out. And the money is there, the intent is there. Let's—let's do a good job.

Indian contractors, these are coming again from the locality to the—to the national levels, because I do represent another board on the national level. But we need Indian contractors. We don't have any right now.

Title VI, of course, is where I'm coming from. There needs to be an increase in funding. Not only in fiscal year 1988 but with a supplemental appropriation to bring Title VI to its fully authorized appropriation—authorized level of $13.7 million. But the Sioux Nation Commission on Aging feels that the fiscal year 1989 appropriation should be increased to the authorized level of 16.2 million.

Most of these were just summarized. If Mr. Pressler—Larry.

Mr. PRESSLER. Larry.

Ms. GARREAU. Senator Pressler, you're going to be on our mailing list. And if indeed you want pages and pages of what we've done over the last 3 years, I'd be most happy to send them to you.

Mr. PRESSLER. Good.

Ms. GARREAU. In summary, I guess I'm saying, come join with me and sincerely in our sincere task of caring for the elderly—become very sincere in our task. I thank you.

Mr. PRESSLER. Thank you very much for that moving testimony. It's very important to hear your concerns. They will become an important part of the record.

I now call on Elaine Quiver of the Foster Grandparent Program in Pine Ridge. Her topic is the Foster Grandparent Program.

Ms. QUIVER. I thank you very much.

TESTIMONY OF ELAINE QUIVER, DIRECTOR, FOSTER GRANDPARENT PROGRAM, PINE RIDGE, SD

Ms. QUIVER. I think you all know me, the people that live in Pine Ridge. I think even the Cheyenne River people know who I am.

I like to—the first thing I'd like to do is express my appreciation for letting Senator Pressler speak to our needs and concerns and feelings of our Lakota people.

I think one of the Foster—as a Foster Grandparent Director on the Pine Ridge Reservation for the last 10 years I really don't need to express the problems and the needs that we have here. Because, as elderly, you have known to share the problems that we have here.

But we do need to tell Senator Pressler the concerns and the feelings that we have pertaining to our existence here in Pine Ridge. A lot of times it seems like we're never heard by anyone other than ourselves or each other. I think "The Forgotten Population" is very appropriate for this hearing.

Maybe this isn't the only time that Senator Pressler will come here. I would like to invite him back and have him send a team to audit some of these programs and to see if they're really filtered down to our elderly and their needs. Because I think most of the time the money is intended to be providing a basic human need here on the reservation. And sometimes I think we—it hasn't reached our elderly. And I think maybe times have come—maybe today is a good day to say that we need Senator Pressler to hear the testimonies that is really needed and drastically needed here in Pine Ridge.

I think it was last week that I read on KILI my testimony to Senator Pressler. And he has my written testimony. And I don't imagine I need to read it again because you all know how I feel. And instead of my reading my testimony again, I would like to share my time with some of the people that are here that would like to give their testimony to Senator Pressler.

The first person I'd like to ask time for is Frank Marshall. I'd like to have him come up and say a few words because he's our fifth member of the Oglala Sioux Tribe, and I'm sure he is aware of our needs for the elderly.

[The prepared statement of Elaine Quiver follows:]

A STATEMENT OF THE FOSTER GRANDPARENT PROGRAM PREPARED BY
ELAINE QUIVER, DIRECTOR
"THE AMERICAN INDIAN ELDERLY:
THE FORGOTTEN POPULATION"
HEARING BEFORE THE SPECIAL COMMITTEE ON AGING
JULY 21, 1988
PINE RIDGE, SOUTH DAKOTA

The first thing I would like to do is, to express my appreciation for this opportunity to speak to you on the needs, concerns and feelings of of my Lakota Oyate (the society of people known as Sioux).

My name is Elaine Quiver. I am a Lakota woman from Pine Ridge, South Dakota. I am the Foster Grandparent Director here on the Pine Ridge Indian Reservation for the past ten years, although the program has existed for 16 years. Today, I am going to express the needs and problems that we have on the Pine Ridge Indian Reservation. This does not mean that I am here to complain or to ask for sympathy for those of us that live here. It is not naccessary to go begging for my people, because we are here with set laws and federal regulations. Traditionally, age and experience have been vital and dynamic parts of the Oglala Sioux way of life. Oglala Sioux elders were held in high regard, listened to, honored, and included in the on-going life of the Indian community. With the coming of a more complex society, the elders were expectad to become spectators to the drama of life, not participants. Their place had been lost, their voices ignored. Simultaneously, a loss of tribal and cultural values among children and the youth became evident, creating a spiritual and moral vacuum. Implementation of the Fostar Grandparent Progran in 1972 began to fill the void for some 150 children who were apathetic, disinterested and involved with various types of drugs/antisocial behavior. Indian society has become even more complex and technical, children and youth with exceptional needs are more readily indentified and a realization that older people can provide a meaningful service to greater numbers of children with special needs, by advice, counsal, extra parental love and knowledge has emerged.

Since 1972, the project Foster Grandparent has been implemented on the Pine Ridge Indian Reservation. The first six years were sponsored by the Oglala Sioux Tribal government, than the tribal government let the Foster Grandparent Program be implemented and maintained by non-profit board of directors. The Foster Grandparent Program on the Pine Ridge Indian Reservation have been budgeted for 44 volunteers. These volunteers have been a highly valuable factor to the special and exceptional children. However, certain elements in the project need to be resolved:

1. Transportation
   --Geographic isolation coupled with shortage of transportation cause hardship.
   --Volunteer stipends do not currently keep up with the cost of living.
   --Lack of equipment on existing buses to handle handicapped.
   --More funding and local planning.

--Uniform cut-rate cost for seniors set by national legislation.
--Great concern over lack of transportation in rural areas
--Better design of buses for elderly and handicapped, including easier access of boarding and disembarking, adequate cooling and heating.
--Car insurance discrepencies against elderly should be investigated.
--Need for reimbursement to transport volunteers by host agencies.

2. Older American volunteerism
--Need more funding in Pine Ridge to use more elderly in schools.
--Volunteer stipends do not currently keep up with cost of living expenses.
--Like to see action emphasize SCP as valuable way to foster independance of older Americans.
--Lack of proper office space.
--Waiver for 10% match, because of being a reservation, most programs are operated on federal funds.
--Need support from local governmental entities support in tribal county and state.

3. Legal assistance, advocacy, legislation
--Priority and drastically need lawyer for the Pine Ridge Indian elderly to interpet regulations and be a legal counsel.
--Unbiased official (federal government representative) stationed locally to represent older persons.
--Senior citizens to represent older citizens at all local legislative meetings.
--Groups of senior citizens to promote housing rights, etc.
--Any committees established to represent "aging" issues should include 50% older persons.
--legislatures (tribal, federal and state) should coordinate efforts to assist elderly.
--Need for simpler language in legal contracts.
--Need to change elderly SSI decrease in summer months instead of winter, which, stems from annual individual land owner lease.
--Need a congressional hearing or audit of all programs including employment, existing personnel regulations in tribal, federal and state.
--Voting assistance given and information about alternative ways of voting should be made available to all elderly and handicapped individuals.

4. Social Services
--Increase number, funding of senior centers.
--More recreational and social activities.
--Need for more homemaker services.
--Need to directly contract aging programs.
--Need for bilingual office on aging on the reservation.
--"Help" telephone lines for elderly.
--Audit the existing programs to assess the needs.

5. Health Care and Maintenance
--Increased aid needed through revision of Medicare and Medicaid (more flexible guidelines, simplifications of forms to expedite processing).
--More home health services in order to help elderly stay in own homes longer through public health nurses, community health representatives.

--Homemaker and chore services expanded.
--Great concern over high cost of quality medical care.
--Pine Ridge Oglala elderly need a good doctor for the elderly.
--Need a skilled nursing home.
--Nursing home care seen as too expensive; should increase in-home care services.
--Up-grade nursing care for elderly; motivate by offering scholarships and other monetary incentives for students and trainees in this field.
--Family training for home health care.
--Burial insurance should be researched.
--More emphasis on preventative health care through self-help programs and education.
--Widows on low-income should be able to draw Medicare, Medicaid benefits at age 60.
--Revise Medicare, Medicaid to cover:
optical (glasses, lens)
dental (dentures)
prescriptions (more complete coverage)
chiropractic services
--Increase availability of exercise programs to enhance older persons mobility cardiovascular abilities, over-all self concept.
--More hospices needed.

6. Nutrition
--More home delivered meals advocated; feel that federal subsidizing of program would allow more nutritious meals.
--Food stamp program should be expanded for seniors based on need (not financial) basis due to special diets often required by patient's physician.
--Carry-outs should be available to senior volunteers.

7. Adequate Retirement Income
--Social Security payments should keep pace with inflation; current benefits of Social Security not adequate.
--Change in Supplemental Security Income guildelines needed.

8. Housing
--Better design homes for elderly.
--More low-rent housing units to be built; filled by formula based on need rather than date of application.
--Use of unneeded school buildings (or other available houses) as facilities to meet elderly's needs - one or two bedroom units and etc.
--License boarding houses for elderly.

9. Employment
--Increase in employment agencies devoted to placing older people in jobs (50-60 years of age).
--More part-time employment opportunities for elderly.
--Plan and development of a craft market by elderly artists.

--Training programs for ages 50-60 years of age.

10. Minority Elderly
    --Ways to assure adequate share of resources, and attention to redress the imbalances which still persist among minority elderly who suffer multiple jeopardies.
    --Share expenses, housing and daily travel.
    --Retirement and nursing homes on reservations.
11. Crime, abandonment, and abuse
    --Vulnerability of elderly to criminal actions and general fear it causes within them as group.
    --Better neighborhood security.
    --Restitution of elderly victims.
    --Prevention programs should be instituted and increased.
    --Enforce existing laws and codes.

44 volunteers are stationed in one pediatric ward, 11 headstarts, 4 parent/child centers and 10 schools. They have provided one-to-one service to 150 children. Many positive goals were achieved such as encouraging the children to participate in classroom activities, help the children maintain their daily basic human needs. The Foster Grandparent volunteers have maintained their traditional Indian values and their cultural heritage. The Foster Grandparents philosophy is to have the children identify themselves as being a descendant of a Lakota with the traditional values and culture, by doing so, a child will be contented and grow into the bi-cultural world as we are today. The Foster Grandparent Program has enhanced the elderly to participate in activities with the youth. The Foster Grandparent Program has maintained a well balanced programmatic system and has been audited twice. The audits were good with no question on costs. (Copies are included in this testimony). Being the only all Indian Foster Grandparent Program in South Dakota has made our project unique. Two national directors have visited our project in Pine Ridge in 1985, 1986 and 1987. We are honored to have an all Indian Foster Grandparents program with the richness in Lakota values and traditional culture.

Although, there are over 1,700 people on the Pine Ridge Indian Reservation who are 60 years of age and over, the Pine Ridge Reservation also has 6,808 youngsters under the age of 16 years old. Due to extreme unemployment of all workers on the Pine Ridge Reservation, a rate of 97% older people are not priority for employment and job training programs offered under tribal jurisdiction. In addition 70% of all reservation households have an income of under $3,500, with elderly income even more diminished. Furthermore, because of the nature of unemployment and isolated communities of the general population manpower needs within the reservation, especially for transmitting information and up-dated regulations, or availability of immediate employment. Because of the severe elements on the Pine Ridge Reservation, basic human needs are rendered by the Foster Grandparents.

TESTIMONY OF FRANK MARSHALL, FIFTH MEMBER, OGLALA SIOUX TRIBE

Mr. MARSHALL. Thank you, Elaine.

Mr. Chairman, Members of the Committee, Ladies and Gentlemen, my name is Frank Marshall. I am a fifth member of the Oglala Sioux Tribe. And on behalf of the Oglala Sioux Tribe, I would like to thank the committee for the opportunity to present testimony on the vital issue of the needs of our elderly.

The term "Forgotten Americans" is sometimes used when discussing the American Indian. In actuality it's more appropriate for those over 65 years old. No other group is more forgotten when it comes to employment, housing, social services, and so forth.

Being old means many things. It means a slow deterioration of what you once were. It means having to eke out an existence on $183 a month on Social Security or perhaps $211 on State welfare. For many of the elderly, living in a substandard house is a way of life, with no running water or electricity. Health care is minimal, with Indian Health Service hampered by funding constraints.

A news article recently stated that Congress appropriated $13 million for economic development for the country of Ireland. This is a country where the Catholics and Protestants are waging war against each other and many people have been hurt because of this. Had this money been used at home, perhaps some of it could have reached our "Forgotten Americans."

On the Pine Ridge Reservation, there exists only one Old Age retirement home. This is the Cohen Home, which is supported in part by the Tribe. A second home is located in Martin, SD, and this one is for anybody who needs the care these facilities offer. Living in these facilities has sometimes been compared to the convicted people living on "Death Row". In both instances, the end result is the same, you are only waiting to die.

The people who draft Federal legislation and are responsible for most of the language in bills need to get in touch with the realities of life in Indian country. Some legislation that has been enacted seems to be directed toward those who can least afford to comply with the law. An example of this is that any income received by a welfare or Social Security recipiant, regardless of the circumstances, would be used to offset the individual's monthly check. On the Pine Ridge, this means that once a year an elderly person may receive $200 to $300 in lease money, but because of the regulations, their monthly check is withheld until the offset is equaled. Perhaps much needed household items could have been bought with the extra money, but knowing that they won't be getting next month's check, they have to use this money for their necessities.

There are many needs; and I will attempt to outline what should be done to meet the needs of our elderly.

In the housing area, inadequate funding makes it impossible for the elderly to be assisted in improving the substandard homes they are now living in. The present programs must be continued and more funds made available by Congress. This would include both retirement homes and assistance in renovating those homes which are now in need of repair.

Energy assistance: It's vital that during the winter months that additional funds be made available to the elderly to help them pay their heating bills.

Meals for the Elderly: This program provides the only nutritious meal that most of the elderly receive on a daily basis. It struggles along with limited funds, yet manages to reach most of its targeted areas. Better kitchen equipment is needed at most serving sites; and what little they have is old and in need of repair.

Health care: Diabetes is rampant among the American Indians today, and this is especially so amongst the elderly. Many of our diabetics have to undergo dialysis treatment and must travel 50 to 100 miles one way to receive this treatment. The Indian Health Service is unable to expand their dialysis program to the outer parts of the reservation. Elderly on set incomes can ill afford the expense for travel for the treatment. Funds need to be made available so an expansion can be done to meet this priority need.

I have touched only the tip of the iceberg with the issues that I have listed. I am aware that there is no easy solution for the problems that face our elderly. Elderly program funding must not be decreased and must be increased to be effective. The present programs are merely band-aids applied to a large wound, and it is simply not enough.

In summation, gentlemen, we need to work together to upgrade the programs that serve our elderly. The problem is not restricted to the reservation, although the problems are more evident here. It is not a Republican or Democratic problem, but it is a serious and deadly one that needs our combined attention. We, as Americans, should not let this problem get out of hand in this, the richest country in the world. I thank you for your attention.

Ms. QUIVER. Thank you, Frank. I'd like to have also Chief Oliver Red Cloud give a testimony on behalf of our elderly.

TESTIMONY OF CHIEF OLIVER RED CLOUD, CHAIRMAN, EIGHT RESERVATION OF OLD PEOPLE

Mr. RED CLOUD. Thank you, Elaine.

(The Lakota language was spoken at this time.)

We have come here to see—hear some of our problems. And I'll be sitting there listening to some of the young people talk and what their problem is now today. In our reservation I work with the older people and the tribal council and the superintendent and eight reservation. I'm chairman of eight reservation of old people. And I hear a lot of problems, Indian problems in all the reservation and especially here.

And what these young people tell you today, it's what happened today. And we have a lot of problem. We could sit here and talk to you all day. But I don't think like the old people say, "Chief from Washington come here, and we talk to our problems with him. They've never done nothing." Now here we are in 50 years under their tribal government. And on the other side we have a treaty, and through that they're supposed to take care of us. And today, I don't see that happening.

And I've been working hard for the generation that's coming, and there's some more coming. And there's no future for them

today, nothing. I don't see nothing today. That's why we have all these problems that the Indian Bureau promises to take care of. And I don't think it never work. And I didn't see it working today. That's why we're here.

The people here tell you about—they have a paper here to read. I don't do that. I come in my mind. And I work hard for these people here as a chief.

And they're going—you're going to hear some more—some of their problem. And I hope you go back and see some of these here and look at your Indian people in this country. We are the first American in this country here, and we still have problem, all kinds. There's no future for the generation that's coming. So that's all I have to say. And I hope you do something about it. Thank you very much.

Ms. QUIVER. This will conclude my time here. It's limited. But I do want Senator Pressler to come again in the near future and do some of the research that needs to be done on this existence of our elderly, not only here, but in all the other reservations.

We should have more input in what goes on in Washington to set regulations and policies that affect all the people, not just the metropolitan areas. And I'm really glad that you came back. I've known you for a long time. And I think you know that we do need your help. And you—at one time, you were a very liberal. I think you need to get back to be flexible to meet our needs. Thank you.

Mr. PRESSLER. Thank you very much. I think your testimony is excellent, and I really appreciate it.

Let me respond to your point that Federal funds sometimes are misspent, and of the need for audits. On the one hand, many individuals advise giving block grants to States and to Indian reservations and letting them spend the money on their own. Some of the money can then be misspent.

On the other hand if we have Federal audits, with that would come Federal control. We would like to avoid that. But if necessary, it will be done. Those are some of the dilemmas we face.

If you have more Federal control, you may have less money misspent. But if you have a block grant, then you run into the problem of money being misspent. This is a good point we must address.

Next we have Vernon Ashley from Pierre, who is a good friend of mine. Vernon is one of our most distinguished senior citizens in the State. He has been to my home. My wife, who couldn't be here today, thinks a lot of him. We all do. I think he's been an adviser to four or five South Dakota Governors, maybe more.

Vernon's been a Senior Citizen Intern in my office. Each year, a senior citizen from South Dakota spends time in my office to advise me on legislative issues I must consider on the Senate Special Committee on Aging. I really appreciate his being here today to testify.

So with that introduction, I now call on Vernon Ashley.

TESTIMONY OF VERNON ASHLEY, PIERRE, SD, PAST STATE PROGRAM DIRECTOR, ACTION

Mr. ASHLEY. Thank you, Senator Pressler, and to the Special Committee on Aging. My name is Vernon Ashley. I'm now retired

after 34 years of service. But in that time I think I've gained a knowledge, and I'd like to share my views with you.

I understand that my topic is supposed to be those services which are available in communities throughout South Dakota or in the Dakotas.

You know, it's—it is especially fashionable to be aging, especially for us who are elder members of the tribe. I say this because throughout the years of living, we have gained a lot of knowledge, a lot of experience. And I say this to my former Foster Grandparents because I was a State Program Director of ACTION.

Because, as I said, they have acquired a knowledge and can leave this with the younger generation. So you've got a world of that knowledge in your hands that you should leave before you leave this earth. But with that, the young people today would just cherish the ability to know just what you know. And with this experience and knowledge, we could do something for ourselves as well. As you can see my white hair, I am a senior citizen. I was Senator Pressler's intern in 1987.

Now in my 14 years experience as a State Director of ACTION, the Federal agency for volunteers service for North and South Dakota, I had the opportunity to see those services that are available to the senior citizens of America. Most of my projects were in white communities or Caucasian communities, and I could go to Dickinson, Mandan, or Fargo or Sioux Falls or Rapid, Aberdeen, any one of them.

And if you want to visit a senior citizen center where there is really an activity, you should visit there because all of the benefits of the Older Americans Act are available here. I always talk about Huron because it's closer. And if you go to the Huron Senior Center, you'll go in there, you'll find every office in there is set up to help the elderly. And that may be transportation, that may be health matters, that may be helping to—help you with your income tax preparation, arts and craft, or just fellowship, playing cards and games and visiting and stuff like this. But that's in these programs I administered through ACTION, the older Americans volunteer programs.

Now I'm sorry to say that I only have one program on the reservation. That's the Foster Grandparent Program here on the Pine Ridge. And I want to linger on that point, Senator, for a while because I think the needs of the elderly on the reservation are just as important as any other community in the Nation.

The things that ACTION programs could help are the Senior Companion. Senior Companion programs are like the Foster Grandparent Program. They are paid a small hourly wage for 20 hours a week to help other senior citizens who need—who are disabled or they're shut in or handicapped. And if you got another able-bodied senior citizen to help them, it would prolong their life a lot longer. And without nursing homes available, I think a Senior Companion could really help.

And I know what they're going to say. ACTION is going to say, "We only have a limited amount of dollars, and the Dakotas already have too many of those programs in proportion to their population, you know. And I agree. Our population in the Dakotas is really low put together. I guess we're a little over a million, a mil-

lion two, in there. But still we keep a lot of our senior citizens in the Dakotas.

So therefore I think the Congress should take another look at this and say, "We got to work up a little better ratio so we can help the elderly who stay in the Dakotas, especially the elderly on the reservation." Most of us stayed. You know, we stay on the reservation, so the problem stays there. And I think that's one Federal agency that could do something is ACTION. As a former State director, I say this.

And the other point is, like the Foster Grandparent, when it was established in 1972, for the first 6 years it was administered by the Oglala Sioux Tribe. Well, there were problems in that time in administering the programs because of misuse of funds and something, so ACTION lost about $13,000 in the process.

But after they became a nonprofit corporation and had their own Board of Directors, it began to continue. We had one director. Ms. Quiver's been there for 10 years, and she's continued to maintain this program. I think that most of our programs—ACTION is going to tell you, "Well, we'd like to put a program there, but we don't have a decent sponsor." Well, I think we can establish these through nonprofit corporations which could be under Federal law.

Because then when we have more Foster Grandparents, more Senior Companions, we could then secure another important item: transportation. I've—in my testimony I submitted to you, I elaborated and explained why I say this, because here we cover great distances. Just to come here today, I came and stayed overnight at Martin and I came here this morning. But just a tribal drive on this reservation alone it takes a few hours to get from one end to the other.

Well, if the tribes would incorporate, they could incoporate on a State and Federal law, get a contract number, and then apply it to the GSA, General Services Administration, the GSA, which has buses. I was just looking them over the other day. And why I say the GSA is because they got a built-in maintenance system. And you know, as you see out here, the garages are far and few between. So if you had the General Services Administration, it would—they would be a better system of control and maintenance and so forth. And then it would provide the transportation to our elderly.

There is no reason under the sun why the senior citizens of Pine Ridge can't come to the State legislature, to visit there for a day, you know, like all the other senior citizens, like in Aberdeen, Huron, Mitchell, Sioux Falls. Bus loads come in there just to witness to see what's going on with the South Dakota Legislature or some type of meetings with the Governor. Our elderly should do the same thing. But without transportation that's pretty difficult.

I guess that's—I'll get off of those programs. But I want to—I have elaborated on all these things. Now a lot of our programs of ACTION are the Retired Senior Volunteer programs. But we can't expect the elderly to volunteer when they're already in a low income bracket. So the RSVP would not be a fitting program on the reservation. But I think that Foster Grandparents should be expanded, the Senior Companion should be expanded.

I think a better system of transportation should be provided to our elderly on the reservation. We should develop on our reservation—and I'm trying to help my tribe develop a multipurpose center where you can have all these things that I've witnessed throughout the country and throughout the Dakotas.

And at Crow Creek, why, they think the senior center is just to have meals. They're only open a few hours a day. They'll go get the seniors, feed them a meal, take them home. They should be able to stay there and do other things, you know, socialize. They can—they've got a lot of ability in making of craft. I've got two of my relatives who are now making star quilts on the Crow Creek and doing a beautiful job. And they can sell those things for a pretty good price and supplement their income.

And I want to say that the non-Indian community is interested in our Indian elderly. At Crow Creek somebody—they said they didn't know who gave them a big television set. It's—it's probably a 24 inch that they can watch and they can even play videotapes, you know, or VCR I guess they call them. And we—my wife and I, we got sewing machines and tables and stuff like that for the senior center so they're active and they're producing.

But more needs to be done. Because somehow they're scared to death of a corporation. You know, they'll say, "My gosh, oh, you're going to be responsible, and you may get sued." So there are misconceptions about a nonprofit corporation. And I'm an advocate of the corporate structure. So I think that that is the two that we, as Indian people, should realize we could use of our own benefit.

And I want to tell you and end by saying I appreciate the opportunity, Senator, and I wish that all the congressional delegates of South Dakota would have Senior Citizen Interns in Washington because my week spent in Washington in 1987 was real beneficial because you see other interns throughout the country, and you find that—well, there was just hundreds of us. It was really an interesting experience. And it gave me the opportunity to speak up in terms of senior citizens of South Dakota and the elderly Indians as well. And I thank you for this opportunity.

[The prepared statement of Vernon Ashley follows:]

TESTIMONY TO THE SPECIAL COMMITTEE ON AGING

JULY 21, 1988

By Vernon L. Ashley

Ladies and Gentlemen of this special Committee on Aging, it is a privilege to have this opportunity to express my views and to say that it is fashionable to be a senior citizen especially of the American Indian race. There are many of the younger generation who cherish the thought of gaining the knowledge we have attained through the years of living, because we are the remants of a great race, and in our midst there are many who have gained the knowledge, experience, and ability to do something in our own behalf. Later in my statement reference will be made as to why we need to utilize such capabilities that are available on or near reservations. On the other hand pertinent information relevant to the benefits contained in the Older Americans Act need to be propegated in American Indian communities, and this Committee would be surprised to find what little is known about O A A benefits on our Indian reservations.

In my fourteen years experience as the State Program Director of ACTION for North and South Dakota, I worked with a considerable number of Senior Centers, plus their Advisory Councils, and I had the opportunity to witness the full use of benefits made available by the Older Americans Act. In a comparative way a very limited number of Older American Volunteer Programs of ACTION are implemented on Indian Reservations, and the American Indian elderly would greatly benefit from the Senior Companion Program, in two ways. First due to the complete lack of nursing home facilities on reservations, Senior Companions could ease the remaining years of those handicapped or disabled elderly in their own homes. Secondly, a majority of the able-bodied Indian elderly would qualify to be a Senior Companion volunteer, because they meet ACTION's low-income requirement. Furthermore Congress can amend the criteria for the Foster Grandparent program, by permitting Foster Grandparent volunteers on Indian Reservations to assist other Indian elderly. We have one Foster Grandparent Program on an Indian reservation, and that is on the Pine Ridge Sioux Indian Reservation in southwestern South Dakota, and there were occasions when ACTION's Denver Regional Office tried to terminate the program, because it did not operate like its metropolitan counterparts. I hope that Committee Members will bear in mind that the mores, customs, folkways and lifestyle of a metropolitan area, and that of an Indian reservation are distinctly different. Therefore, this Committee should make recommendations to the United States Congress to amend the law; so that programs already initiated by the Congress could be implemented in Indian country. ACTION should be required to evaluate how these Older American Volunteer Programs operate on one reservation to the other, and not in comparison to a metropolitan or caucasian community. Another ACTION program that could be helpful to the American Indian elderly on the reservations is the Volunteer in Service to America program, as special volunteers could be recruited from a national area, and in that manner needed skills to develop and implement projects for the elderly can be initiated. The reason for such Volunteers is that the administrative and

developmental skills are needed from an outside source. It is my contention that Peace Corps volunteers should be made available to Indian Reservations. In this manner the Peace Corps volunteer can serve for a longer period of time, and there is a dire need to have continuity to properly implement such programs. I contend that our Indian reservations qualify for Peace Corps services. From a legal standpoint the American Indian qualifies because the United States Government made treaties with the Tribes as sovereign nations. It would seem feasible for the United States Congress to direct this country's tax revenues toward the solution of problems plaguing communities within the confines of America, and the assistance would be appreciated. I highlight the foregoing programs because there would be no need to enact new laws to accomplish assistance to American Indian reservations where the elderly stay as long as possible.

This Committee needs to evaluate the programs being administered by the Department of the Interior's Bureau of Indian Affairs, as the said Bureau needs to streamline its services. Such programs as the General Assistance welfare program has created a dependant society. I agree that it is needed when it pertains to the disabled, handicapped or the elderly, plus those who cannot work. It should be discontinued for those of a younger age category. We are concerned about the senior citizens of the American Indian population, and the funds allocated by the Congress should be earmarked for the senior citizen population, to build large adequate facilities that can be used for services for the elderly. The Congress should require the Bureau of Indian Affairs to direct more resources and staff toward the specific welfare of the American Indian elderly.

I have referenced my experience in working with Senior Centers throughout the Dakotas, and I would like to linger on the subject for a moment. Through ACTION I had Retired Senior Volunteers working and assisting in different categories of senior programs. Almost one-hundred percent of my programs were in caucasian communities, and in these Senior Centers there was transportation for the elderly, depending on the size of the community there may be more than one mini-bus; handicraft was produced by the elderly and marketed out of the Senior Center; health programs to monitor blood pressure, etc. were available; balanced diets were provided in a pleasant atmosphere; plus fellowship in a card room, pool for the men; and each month birthday recognition programs were held. Now let us reference an Indian reservation where they are lucky to have a meals program. The elderly may or may not be transported to the meal site, a meal is provided, and then they are transported back to their homes soon after. It seems there is very little interest in initiating other activities that would be helpful to the senior citizen. One of the hindering factors, I understand, is that federal funds are made available directly to the Tribes through Title VI, and the elderly may or may not get the full benefit of such funds. The State's Adult Services and Aging Office informs me that they are not permitted to intermingle Title III funds with Title VI funds, and this is detrimental to the senior programs on the reservations.

Let us take a look at the other side of the coin, because there are reasons as to why the benefits are not available, and in some cases it may be due to the lack of a good administrative set up. With reference to ACTION's Foster Grandparent Program, initially the Oglala Sioux Tribe was the Sponsor, funded in June 1972, and in the Administrative changes caused by elections, funds were lost in the shuffle. It was during a few trying years that Sponsor change had to be initiated, and a Non-Profit Corporation assumed sponsorship. Since then one Project Director remained with the project, and the Foster

Grandparents have met the needs of school children throughout the reservation, with a little different emphasis than a metropolitan project, but this highlights the fact that a corporate structure may be an answer to such an administrative need. On the other hand the important aspect of a Non-Profit Corporation is the members of the Board of Directors. There is a dire need to search out progressive thinking people, and they may be members of the clergy, the spouse of a successful farmer or rancher, a local store operator, plus some local senior citizen who has retired returning to the reservation, because you need active, responsive, plus progressive thinking people to make the plan work. With due respect to those elders who have resided all their lives on a reservation, have not gained the experience, and may not be able to contribute toward the development of a multi-purpose center, and this may contribute to the problem that prevails. Therefore, the make-up of the Board of Directors is important, and without such a Board, the corporate structure will fail. Therefore, I implore this Select Committee to keep in mind that the reservation communities need assistance, in the form of expertise to formulate, from beginning to end, the development of a sound administrative set up, so that an Indian community can ferret out the benefits of the Older Americans Act.

I have assisted my reservation to do just that, preparing the Articles of Incorporation, educating the senior group on what a corporate structure can accomplish for them, if, a good board of directors could be assembled, and some improvement can be seen at the Senior Center, but more needs to be done. The Indian communities need to visit on-going multi-purpose senior centers, and then they will know what to strive for, because without such knowledge, they cannot set their goals.

The Federal Agency for Volunteer Service (ACTION) could be very helpful to the nation's American Indian reservations by implementing Volunteers in Service To America (VISTA) projects for the specific purpose of developing Multi-Purpose Centers, from beginning to end, and such Vista Volunteers will render a needed service. ACTION had some bad experiences on reservations but that again was due to bad sponsorship, and with proper initial planning this can be alleviated. The Bureau of Indian Affair's staff can direct more resources toward assisting the elderly on the reservations, and with the coordinated effort of Federal Agencies, and the State Agencies, services for the senior citizens on the Indian reservations can be improved.

The benefits made available by the Older American's Act are applicable to the American Indian elderly, the sponsor of the projects need to design the services that fit their needs, and all of the foregoing factors need to be taken into consideration.

The program that is available on the reservation is meals, and that constitutes what they conceive as a senior center. I do not believe that aging hesitates for any race, but we need through existing federal programs to alleviate and prolong the life span of senior citizens of Indian communities, and this can be done by establishing strategically located nursing homes for the American Indian elderly. I highlight nursing homes because the American Indian elderly must leave the reservation to get the services of a nursing home, thus leaving their relatives and friends and be amidst people of a different culture. This is the cause of early passing because they become homesick and they have nothing of familiarity.

We should take into account the fact that our American Indian elderly possess skills, in the production of craft items such as quilts, bead-

work, quill work, and they should have the opportunity to pass on these skills. The Crow Creek Golden Age Center after the implementation of their new Non-Profit Corporation have started the production of star quilts and two people with the needed skills are producing. There is a continuing need to get the elderly involved.

Transportation is an issue that needs further study. In comparison to South Dakota's non-Indian communities, and their Senior Centers, transportation is very limited on Indian reservations. The distances are greater, the vehicles in Indian communities are of an older vintage, and there is a need, but there is a need to control the use of transportation for senior citizens. At one location, namely the location where the hearing is being held, the Urban Mass Transit Administration placed five Mini-busses,with the Tribe being the recipient, and without controls the busses were soon inoperative. In any event, the need is there, and with the development of a sound administrative set-up, transportation should be made available to the American Indian elderly. The additional problem in Indian communities is that of providing a storage facility (a garage to be specific), so that the vehicle can be protected from the inclement weather, from vandals, and to prolong the life of the vehicle. It would seem practical for the General Services Administration, Interagency Motor Pool system to provide the Mini-busses to Centers sponsored by Incorporated Bodies of the American Indian Reservations. The Administrative Body could be incorporated under federal law, a contract number assigned. My reason for such recommendation is that an established system of maintenance can be utilized. At the present time, the Inter-Agency Motor Pool is providing vehicles to different programs on the reservations, and this could be implemented.

Outside organizations, or groups, are willing to help the elderly on the reservations. Recently the Crow Creek Golden Age Center received a large screened console television set, plus an individual gave about thirty electric fans, because of the extreme warm temperatures this summer, and the donors remained anonymous.

In conclusion I want to reference Art Linkletter's book entitled "Old Age Is Not For Sissies" Choices for Senior Americans, a resource book that has some meaning to senior citizens. I hope that this Senate Special Committee can make recommendations that will equip the senior Citizen on Indian reservations to stand up for themselves, and implement the benefits of the Older Americans Act. There is a continued need to provide information on programs available to all senior Americans.

I appreciate this opportunity, and in the event further information is needed on any aspect of my testimony, I will be obliged to provide it.

Mr. PRESSLER. Thank you very much for your outstanding testimony.

I wanted to say that hearing you mention star quilts brought to mind one of my wife's and my most prized possessions—a star quilt. It was made by the late Florence Tibbetts who recently passed away. I know her son is here today. Her family has really been good friends of mine. Over the years, my wife has really enjoyed her visits here. It's always a pleasure coming back.

Vernon, I think what you said here today regarding the Senior Citizen Intern Program provides a unique perspective on aging issues. For that, I thank you very, very much.

Next, I'm going to call on Royal Bull Bear from Kyle, who is going to talk about his experience as an older native American Indian.

The committee is very interested in and eager to hear your testimony, Royal.

TESTIMONY OF ROYAL BULL BEAR, KYLE, SD

Mr. BULL BEAR. Thank you, Senator Pressler, and staff and friends.

I am glad this morning that I have this opportunity to speak to the Senator and other programs. I live in Kyle, SD. At the present time I'm over here at the Hills working with some kids. There are some kids from this reservation go up there and have a camp of a little training. So after this meeting, I have to get back over and work with the kids again.

Now, what I am going to say at this time is I've been to a lot of meetings such as this. And every time at meetings like this we heard reports from different programs. But let me say this from the people of the Gray Eagle, these reports come from offices. It doesn't come from people where the needs are.

I say this because Gray Eagle has been out there, talked with the people. Some of the people are handicapped. And they have no way to come to hospitals or programs. And nobody's been out there to explain what's available for them, so they don't know what the programs are. But the Gray Eagles are out there, talk with his people. And this is what we come up with. I think Senator Pressler has a copy of this, and I hope he took a very good study of this paper. In the future I hope something come out of this report.

Some of this elders need help, and they come to hospital. But they'll have to wait in line so many hours, and sometimes they went home without getting services. I've seen it happen. And I think we need to expand some of these programs so people set up instead of city and offices, go out to the people and talk to them, because they need help.

And another thing: I'm sorry to say this, and I might hurt your feeling, but this is what it is going to take to come up with an answer or solution to help this needy people. We have programs and we have tribal government, but we are in a situation that's bad, very bad. I've been thinking all this last few month, there's no future in the tribal government, no future. So what are we going to do for our children? There's a lot of children. Then it's a very bad situation. Not only here but other tribes. I have been getting phone

calls from different tribes. I don't have the authority; I don't have the power to help those other tribes, but they call on me. And if I can do it, they want me to go over there and talk with them because they heard about the Gray Eagles.

Gray Eagle Society is all the elders. You see some of them sitting back there and back here. They know the situation is getting bad. That's why they form this Gray Eagle Society, to see if we can solve some of these problems. If we don't, like I say, children, there's no future.

So I am not going to go into detail about this paper. But I hope Senator Pressler take a good look at it and study and see if we can get together and come up with an answer.

Now, in closing, I'd like to tell a story. It's a true story at a time when our great-great-grandfathers are still hunting buffalo or whatever. And one time there are 200 hunters went out to hunt. And while they're walking, they heard something, and they know what it is. It's a mean buffalo. This buffalo bulls. When it gets to fight, one of them is bound to get killed. And another buffalo come up and fight with this bull. This buffalo, after he kill so many buffalo, he lost his mind. He's out of his mind. He so mad that he don't know what he's doing. He operates under any option to kill; female buffaloes or calf, whatever. And pretty soon he took off running.

So this two hunters heard buffalo coming, so they run toward where the trees are. And just as they got to the tree, this buffalo caught up with them. The one jumped up and grabbed a limb and pulled himself up, and the other one couldn't make it. And there's a hole down in the bottom there so he crawl in that hole.

So this buffalo started looking around, and pretty soon he come up and see this man there. So just as soon as the buffalo pull away, this man came out. So he seen it and took after it again, but he crawled back in. He done that about two or three times. So this man up there shouts, "You stay in that hole." And this man said, "How can I? There's a bear in that hole."

So I think this is what happened to the needy people. What are we going—where are going to turn? What are we going to do? This is—this is the kind of situation we're in now. And I'm sorry to say this, I might hurt somebody's feelings, but that's all right: Some of you older people know that the chiefs of the elders make this kind of a speech to the people and the people listen to them. Now we don't have that anymore. Nobody give advice to the council or to the young children.

And this is one of the things that the elders are doing now—trying to teach our children so they learn to respect others. We don't have that respect anymore.

Thank you.

[The prepared statement of Royal Bull Bear follows:]

TESTIMONY OF ROYAL BULL BEAR

1. Older American Volunteerism

- need for reimbursement of transportation cost by agency using services of older volunteer
- volunteer services should be directed toward family as whole
- barriers to acceptance and use of older volunteers: age myths, physical limitations, financial problems, inflexible agency regulations, staff attitudes
- agencies should consider needs of volunteers: intellectual stimulation, positive social contacts, better emotional balance
- expand volunteer positions to include:
  cultural aids in museums and theaters
  vocational helpers in schools and universities
  helpers in data processing and research
  widow-to-widow counselors
  advocates for crime prevention, witness/victim programs
  helpers in energy audits and conservation projects
  coordinators in transportation systems
  aids in helping to find senior housing alternatives
- volunter stipends do not currently keep up with cost of living
- further expansion of volunteer programs
- concern with recruiting ethnic or "untraditional" volunteer- not enough men in program (use of male volunteers to recruit)
- fear of volunteer of traveling alone to place of work
- use of seniors in field to search for those who need and will use services and are eligible for programs
- more programs needed in which elderly could work with children; youth involved with old
- like to see ACTION emphasize SCP as valuable way to foster independence of older Americans
- community coordination of volunteer services

2. Transportation

- lack of equipment on buses to handle handicapped
- better community bus scheduling-perhaps institute routine weekly schedule (Mondays-shopping, Tuesdays-doctor's appointments, etc.)
- general expansion of services
- more funding and local planning
- need for increase in weekend transportation
- services to and from church activities
- uniform cut-rate cost for seniors set by national legislation
- offer tax break to oil companies to offer lower gas prices to aged
- great concern over lack of transportation in rural areas
- low-cost housing units to furnish transportation 7 days per week at a reduced rate for minimum needs of tenants as well as emergencies
- better design of buses for elderly and handicapped, including easier access of boarding and disembarking, adequate cooling and heating
- "dial-a-bus" services for shopping, doctor's appointments, etc.
- standard bus rates not Affected by rush hour times for senior citizens
- flat cap fares for local rides for qualifying seniors
- car insurance discrepencies against elderly should be investigated

3. Health Care and Maintenance

- increased aid needed through revision of Medicare and Medicaid (more flexible guidelines, simplification of forms to expedite processing)
- more home health services in order to help elderly stay in own homes longer, through public health nurses, health aides, etc
- homemaker and chore services expanded
- great concern over high cost of quality medical care
- widows on low income should be able to draw Medicare, Medicaid benefits at age 60 instead of age 65
- more emphasis on preventative health care through self-help programs and education
- nursing home care seen as too expensive; should increase in-home care services
- tax tobacco and alcohol sales to help finance Medicare
- programs to help care for elderly who can live at home but need more than 4 hours help per day. Many elderly willing to pay for services, yet cannot find those willing to work

- revise Medicare, Medicaid to cover:
  Optical (glasses and frames)
  Dental (dentures and dental problems)
  Audial Problems (hearing devices)
  Prescriptions (more complete coverage)
  Chiropractic Services
  Accupuncture
- upgrade nursing care for elderly; motivate by offering scholarships and other monetary incentives for students and/or trainees in this field
- family training for home health care
- establish neighborhood geriatric centers for minor to intermediate level medical problems
- implementation of National Health Service
- increase availability of exercise programs to enhance older person's mobility, cardiovascular abilities, overall self-image
- provide larger number of screening programs- Blood pressure, diabetics, glaucoma, etc.
- money should be made available to those elderly who do not qualify for Medicaid but who incur medical expenses totaling 20% of income
- more hospices needed

4. Nutrition

- more [redacted]delivered meals advocated; feel that federal subsidation of program would allow more nutritious meals, larger portions
- teach proper food preparation
- fresh fruits, vegetables made more available; provision for low-cost vitamin supplements
- volunteer program to help elderly prepare evening meals; volunteers could receive academic credit
- help elderly can fruits and vegetables for winter months
- food stamp program should be expanded for seniors, based on need (not financial) basis due to special diets often required by patient's physician
- grocery store on wheels for those unable to get to store

5. Adequate Retirement Income

- social security payments should keep pace with inflation; current benefits of social security not adequate
- more discounts offered for elderly
- widows should be able to draw benefits at earlier age
- change in Supplemental Security Income guidelines needed
- no tax imposed on social security checks
- no tax on incomes of senior citizens who work after age 65
- too much of social security money being spent in areas not originally designated by program. Money should be maintained for retirement benefits only
- national policy which exempts seniors from paying sales tax on food and drugs
- pensions to increase in direct relation to cost-of-living increases
- no tax on savings accounts for those age 65 and above
- federal poverty levels to be reviewed
- credit for homemakers on social security
- equal entitlement to social security benefits to both spouses
- persons taking early retirement should draw full retirement payments after age 72
- need for retirement counseling for those nearing or entering retirement

6. Housing

- need for low-cost housing, which includes smaller private homes, not just high-rise projects
- more rent subsidies to those in privately-owned housing
- more low-rent housing units to be built; filled by formula based on need rather than date of application
- housing to be subsidized, new low-rent housing to be built both to be located in areas of town already populated with elderly
- decrease in property taxes- base according to property and income of individual
- cost of street and alleyway improvements assessed to those elderly [redacted]living in own homes should be subsidized or elderly residents should be allowed to pay in monthly installments instead of a lump sum

- more units for both independent and congregate living
- better design for elderly housing- larger kitchen and storage spaces, freight elevator, air-conditioned laundries, multi-purpose auditoriums, adequate parking
- access to federal government commissaries or federal government satellite commissaries to be placed near housing projects
- change zoning laws to allow mobile homes on privately-owned lots and educate public concerning mobile home living; facilitate acquisition of property
- freeze individual's property taxes at age 60
- institute rent controls
- use of unneeded school buildings as facilities to meet elderly's needs- one or two bedroom units with living room and kitchenette, with bath shared by two units; use of gymnasium as dayroom for housing community center
- license boarding houses for elderly
- emphasize architectural design for senior housing
- promote moving services which cut down on costs for elderly

7.- Employment

- more part-time employment opportunities- suggestions include workers in adult day care centers, outreach workers to other elderly, van drivers for handicapped aged
- tax benefits for employers who hire people of age 55 and older
- suggestion that regional skills pools be formed, administered by board of retired personnel. Retired persons would register skills with board through control bank, for possible employment opportunities.
- development of a craft market by elderly artists
- training and utilization of older persons, particularly women with no employment experience, in areas where life experience can be particularly valuable: nursing care, social services, working with children in day care centers, schools, homes, and institutions
- increase in employment agencies devoted to placing older people in jobs
- innovative approaches for flex time, job sharing, etc. for older workers

8. Education of both older people and the general public

- of professionals (doctors, social workers, etc. needed) to make them more sensitive to needs of aged
- increase in informational services for both youths and adults
- training in financial management for senior citizens
- vocational training for older displaced homemakers
- increasing educational opportunities for seniors
- education for retirement to begin early in life so that the society as a whole is aware of the various problems involved; retirement planned., prepared for
- free tuition for those over age 55
- need for transportation to courses or extension of courses to centralized locations for older persons
- integrate seniors with younger students
- library services available to shut-ins (mobile library)
- promoting independence and dignity of older Americans
- use of media to dispel stereotypes of elderly, present truer image

9. Legal assistance, advocacy, legislation

- unbiased official (federal government representative) stationed locally to represent older persons
- senior citizen to represent older citizens at all local legislative meetings
- groups of senior citizens to promote housing rights, etc.
- any committees established to represent "aging" issues should include 50% older persons
- legislatures (federal and state) should coordinate efforts to assist elderly
- legal services subsidized to draw out wills and other common services
- discontinue school tax payments by elderly
- senior citizens need to know of services such as legal aid since often lack money and knowledge of who can help them deal with legal questions
- need for simpler language in legal contracts
- voting assistance should be given and information about alternative ways of voting should be made available to all seniors and handicapped individuals

10. Social Services

- increase number, funding of senior centers
- more recreational and social activities
- system of tax credits to encourage private business and industry to support or assist in subsidizing activities
- "HELP" telephone lines where depressed and lonely elderly people could call in 24 hours a day
- need for more homemaker services.
- telephone/visitation programs needed to check on well-being of home-bound persons by regular telephone contact or one-to-one visitation
- need for more publicity of available services for elderly within community

11. Retirement Roles

- part-time employment
- community service
- personal fulfillment
- more leisure activities that older persons can afford-dancing, games and exercises as well as trips and tours
- more opportunities for elderly to be with other elderly
- greatest worry of aged seems to be loss of security and well-being that living independently in own home provides; fear of being burden on children or others

12. Spiritual Well-being

- discuss place of religious community in ministering to needs of the elderly
- churches and synagogues should take a more active part in notifying the elderly of services available in the community, and work closer with agencies providing these services
- more visitations, activities; churches and synagogues could assist with transportation to activities of the religious community, and organize special trips or excursions to help meet elderly's need for social contact

13. Elderly Women

- resolve social imbalances of elderly women
- change social security laws and pensions that normally withdraw money from a household when the husband dies
- programs to encourage elderly widows to share homes or apartments; supplemental housing to allow two eligible women to share housing and its expenses
- house repair and yard assistance programs
- night transportation provided to cultural and educational functions for elderly women

14. Minority Elderly

- ways to assure adequate share of resources, and attention to redress the imbalances which still persist among minority elderly who suffer multiple jeopardies
- retirement and nursing homes on reservations

15. Crime, Abandonment, and Abuse

- vulnerability of elderly to criminal actions and general fear it causes within them as a group
- better neighborhood securtiy (neighborhood watch programs)
- restitution of elderly victims
- prevention programs should be instituted and/or increased

16. Research on Aging and the Aged

- provide public education on aging and retirement to reduce negative stereotypes and create a more realistic view
- research within the following fields as it pertains to older persons:
  - medicine
  - social sciences
  - psychology
  - economics
  - culture

17. Age Integration

- increased use of the media (both print and visual) to educate the general public, and draw the generations closer together
- more activities in which both older and younger persons are encouraged to participate

18. Energy

- better energy assistance programs
- subsidize heating costs of needy elderly

19. Emergency Conditions

- workable, realistic emergency plans for older persons in natural disasters

20. Consumer Protection

- increase in number, variety of consumer awareness campaigns aimed at the older population in the United States

Purchasing power of dollar

Senator PRESSLER. I shall next call on Marie Randall from Wanblee, SD, also an elderly Indian witness. We look forward to your testimony.

I know that the group of Indian women sitting here in the front row to my left want to submit testimony in opposition to the sale of the Sioux San land in Rapid City. I have already written a letter urging that the sale of the land be cancelled. However, at the end of the hearing we will hear from them.

At that time, I also will present an award to Elaine Quiver in recognition of her 16 years as the Director of the Foster Grandparent Program at Pine Ridge. Right now, we will hear from our last scheduled witness, Marie Randall.

TESTIMONY OF MARIE RANDALL, WANBLEE, SD

Ms. RANDALL. I'm greatly happy to have Mr. Pressler come down to our reservation and the committee that is with him to hear the grievances and the problems of the Lakota elderlies. And I can't be happier.

(The Lakota language was spoken at this time.)

Ms. RANDALL. My name is Marie Randall and I live in the Eagle Nest District on the Pine Ridge Reservation. Our district is located about 100 miles from here.

And everybody's talking about transportation. I almost not made it this morning. And I'm a wife, a mother, a grandmother, and I have—including my adopted children, I have 13 children raised. And this is—me and my husband raised our family just my husband being a laborer. He was not a—any kind of a—just home life laborer is what—is how we raised our children.

And at this point of my life I thought I was qualified to represent the elderlies because I'm an elderly myself. And living in the Eagle Nest District and being active in the Senior Citizen and the Foster Grandparent Program and the Gray Eagle Society, I thought I would be qualified to represent my people. So that is one reason why I have come here to testify about the concerns of the elderlies.

And as you have heard before, there is a lot of things that the elderlies are having hardships in. And I believe all elderlies that are here present and the ones that are not here are living under a—we are living under fixed income. And I really agree with that, because we're in a fix. We just have a certain amount of money to spend through the month in order to survive.

And the Social Security some of us have earned. But a lot of our elderlies at the age group that they are now, they didn't have no organized work. We didn't have no Social Security at that time of their life. So what they are living on is the Supplement Security Income. And that is something that is helpful to our senior citizen.

And yet there's another way of looking at it—because most of our elderlies are holding onto their land base and their mineral rights because of the feeling they have toward their children and their grandchildren. That is why they're holding their land base and mineral rights. And when they get their SSI for a period of time, and when their lease income comes in, what do the SSI, Supplement Security Income, do, they cut off their income. And this is a very bad hardship. They cut them off a certain period of time ac-

cording to the amount of lease money they receive. And I really don't think that is right.

And the transportation was talked about very much, and I'd like to go into that. Like I have said, I live 100 miles. And I had to go to the school and talk to our principal in order to transport some of my elderlies with me here today. So it is very hard for our elderlies transportationwise. And when we receive our Social Security and Supplement Security Income, we have to think about, "Are we"—"What are we going to spend it for?"

First of all, in order to survive, we have to think about food. And so then we have to travel a distance in order to buy different varieties of food. Someone talked about a diabetes among our Lakota people, so some of them are on diet. And community stores don't carry very much supply of fresh fruits, fresh vegetables, fresh meat.

Our Lakota people, we live on soup, meat. We like—we just love our meat. And one of them mentioned here that they are satisfied in order to have soup three times a day. We're happy with fry bread, wojobe pudding. You know, we live on that. Our ancestors have lived like that. And we, as Lakota people, can continue living like that.

And so, when we get our checks, we have to decide which town we can go to to pick up our fresh fruits, vegetables, meat. And the transportation problem come—comes in there. Kadoka is 27 miles away from our Eagle Nest District Community Settlement. And 27 miles away they charge us $30. Anybody that you have to hire charges $30. And Philip is another town, which is 50 miles away. They most generally charge $45 to $50 a day. Martin is another town 50 miles away from Eagle Nest District, and they charge from $45 to $50.

And then, if an elderly wants different—more different varieties of things or clothing or material stuff, they like to go to Rapid City because there's a lot of choices there and a lot of reasonable priced items that they can pick up. And what do they have to pay, 475 to $100 for that trip. and if a—just estimate a person getting $337 a month. I'm not ashamed to tell my total amount of money that I receive monthly and that I have to survive on.

Now, if we pay somebody $100, that leaves me $275. And if I pay—if I put away $50 for other expenses, for instance, like medical expenses that I might need or if I get sick and I have to go to a doctor, I have to put $50 for transportation. That leaves me about 100 and some odd dollars for my groceries to survive on through the month. And with food prices going up, what do you think? It's not very easy for us elderlies.

We have to budget very, very closely in order to survive. These are not included in our Social Security, our Supplement Security Income.

We have IHS. Yes, we have IHS. But being from that district, we don't expect an injured elderly or a sick elderly to travel 100 miles. And sometimes they transfer them to Rapid City, which is another 100 miles. No, they're suffering enough, so we try and get them to the closest medical attention they can have. And it's the same price again; $30, $35, $40, $75, $100, whatever. Sometimes if a person feels for the elderlies, maybe they charge less. So that is one

reason transportation is very important for our elderlies. And the income is very important.

And besides that, if we want to see at night, we have to think about our electricity bill. If we want to keep warm through the winter, prepare our food, we have to think about our propane. There goes some more of our money. So you can imagine what the senior citizens are going through.

And I was happy—I was scared at first when I received a letter having to come up here and testify for my people. And then I read the topic, "The American" elderly, "Indian Elderly." And then it says, "The Forgotten Population." Yes, that just fits us pefect. We have been forgotten for many, many years.

And Mr. Bull Bear mentioned that here. We educated our children in order that they would be our tomorrows, our future. But I see they get their education, do they look back? No, some of them do not look back at us as elderlies. Some of them, I do not know why, but they think about material things more maybe. And they forget about their relationship and their respect that the Lakotas have for one another. And most of our educated children are Lakotas here on the reservation.

I know with my 10 children, I try my best to educate them. But as a family, I really teach my children the Lakota values and they understand well. And a lot of my people know my children, so I'm not afraid to say this. And so the $50, that's set aside for emergency use, medical use. If we don't use it, it most generally goes to other necessities that we need. And then the best part is coming—when we pay out all the utilities, propane, medical bills, transportation.

And then I would like any of you Senators, Congressmen, Presidents, whoever you are, to come to our Lakota homes and visit us. We welcome you to come and visit us. Because of the money that's allocated to the elderlies, when they get through paying for our survival through the month, we do not have enough for our repair in our homes. That includes broken screens, no screens, broken windows, broken locks.

And for the safety of our elderlies today, we need locks in our doors because of the problem of alcohol and drug on this reservation. We need to protect our elderlies more. And that includes a safety—what do you call the people down there? Why, they make their rounds, but do they get off to visit the elderlies to see if their needs are met? No, they drive around in cars. Boy, I think those safety people have lots and lots of gas because they drive and drive and drive, but they do not come to meet the elderlies and ask them their needs. So it's very dangerous. Not only here on the reservation, but I'm sure in the neighborhoods of the urban towns, cities, it's the same way.

And that is what I'm testifying for my elderlies, the income, the transportation. And we had some meetings because I was going to come up here and testify. And what we come up with was a waiver for the lease income, for the elders, Lakota elderlies that receive that lease income. Although they do not go up to $1,500 but still what money they receive, they should not be cut off their Supplement Security Income. That's the way I look at it.

And another thing that we come up with, a salaried officer, an advocate for the elderlies in local communities; not just one person to represent the elderlies at the council meeting or one representative to visit the nine districts. No, we're looking at the local point of view. A salaried advocate that would look out for the elderlies, the assistance that they can give, information providing for the senior citizen.

And the health care that we need is home health care for our elderlies. Because most of our elderlies are still the head of households, and they play a main family role in the life of a family. They live within the family, and everybody looks up to them and listens to them. And I think we need a home health care.

And someone talked about an elderly complex in each community where the senior citizen can live within the community; they do not have to go off anywhere. And we need an extended care facilities and services. I mean we have Green Thumb Programs, we have Companionship Programs. But the only program that I know of that is existing in this Pine Ridge—on this Pine Ridge Reservation is a Foster Grandparent Program. But the Foster Grandparent Program cannot hire all senior citizens. And I think we need other programs here on the Pine Ridge Reservation for our elderlies.

And housing I just say—wish to invite all of you to come to our homes. Because of the income that we have to live by, our repairs, we sit there and watch our homes deteriorate. What else can we do? It's sad, very sad for our Lakota elderlies.

And the water rights, Mr. Pressler, himself, viewed and seen. And we would like to guarantee protection for our water rights. And that is about all I can bring up. But I hope that everyone here on the committee would view our testimony.

And with the closing, I would like to ask Mr. Senator Pressler and the committee president and thank them for coming here on the Indian reservation to listen and hear our problems and needs. We are the people. All of us here together are living on this continent or on this reservation or other areas. And if we come together like this more often and hear one another, the problems and issues that we have to face together, getting together for more understanding and communication and in betterment of our future; I think we needed to do this more often.

So, Mr. Senator Pressler, when you go back, I would like for you to invite any Congressman. We're not desperate people. We're people here, and you're welcome to come more often to visit us. We have—what we have said here today, we have more to present. But here we are just a few chosen ones that are presenting our testimonies. So let us work together as people and make a betterment of our Nation and the Lakota nation.

I thank you very much for listening to me.

[The prepared statement of Marie Randall follows:]

Senate Select Committee on Aging
Eagle Nest District
Oglala Sioux Tribe
Pine Ridge Indian Reservation
Marie Randall, Eagle Nest Senior Citizen
Wanblee, South Dakota 57577
July 21, 1988

INTRODUCTION

My name is Marie Randall. I live in the Eagle Nest District on the Pine Ridge Indian Reservation. Our district is located 100 miles north east of Pine Ridge. I am a wife, mother, grandmother and have raised 13 children including 3 adopted ones. My husband and I raised our family on his wages as a laborer.

Our family is a traditional Lakota family and we have raised our family to respect the Lakota values. At this point in my life I feel I am qualified to represent the elderly because I am an elderly living in the Eagle Nest District. I am 68 years old and active in the Eagle Nest Senior Citizen, Foster Grandparents Program and Gray Eagle Society. I have come to testify concerning our elderly in order to leave a legacy of hope for my children and grandchildren. The hard life that we, the elderly, have led is not what we want for our children.

In order for you to have a better perception of the life of an elderly living in the Eagle Nest District I present the following:

The elderly live on fixed incomes and I agree we are in a fix. We subsist on Social Security and SSI. I receive my check monthly. Upon receiving this check several decision making and priority processes occur. A decision on food procuring must be made first. I have to decide if I can afford to go to Kadoka, Philip, Martin or Rapid City. Transportation costs from Wanblee to the above areas are: Kadoka - 27 miles - $30; Philip - 50 miles - $45-50; Martin - 50 miles - $50-60; and Rapid City - $75-100.

I must then look at my electric and fuel bills. If I want to see at night I pay the electric bill. If I want to be warm and cook for my family I buy propane. If I decide to go to Rapid City, pay my electricity and buy propane I have spent $200.00. I now have 157.00 left. I then set aside $50 for medical transportation cost if something

occurs during the month. So I now have $107.00 to buy food for the month. The $50 I set aside is primarily for medical transportation costs but usually is utilized for food and other things during the month.

After food, shelter, transportation and medical emergencies, there is no money for clothing this month. I have now spent my money for the month. For other elderlies the same decision making processes must be made. For others this means no screens or screen doors, the lock cannot be fixed on the door; there is no money to buy a fan for the summer months; no money for entertainment or recreation. The majority of elderly utilize their money for basic needs.

I have listed the problems we face daily and will now list recommendations that will greatly assist us:

1. Transportation - Provide a vehicle to transport the elderly for shopping, medical care, personal business, and perhaps entertainment; for example visiting.
2. Waiver of Lease Income - Waive upto $1500 of annual lease income with no loss of Social Security and SSI income, Medicaid and medicare benefits.
3. Salaried Office for Advocate for the Elderly - Assistance and information providing senior citizens in all facets of everyday living.
4. Health
   - Home Health Care
   - More protection for the elderly regarding Public Safety (Security)
   - Extended Care Facilities and Services
   - Ambulatory Nursing Home
5. Housing - Lov income elderly complexes
6. Water Rights - Guaranteed protection of our water rights

Mr. PRESSLER. Thank you very much. We are nearing the end of the hearing. I do want to say a couple of things. I'm holding other hearings on elderly issues. This afternoon, I'm going to Aberdeen to attend a hearing examining nursing home issues and some of the problems associated with financing care in these facilities. We will also discuss the Medicare and Medicaid programs.

Tomorrow I'm attending a program on Alzheimer's disease in Sioux Falls. Dr. Zavin Khachaturian, an internationally known expert on Alzheimer's disease, will speak. I have been working on legislation to increase research funding to find a cure for this devastating disorder. We could save large sums of money in our society if Alzheimer's victims could take care of themselves longer in their own homes rather than being placed into nursing homes.

I also wish to say I am glad to be here again in the Billy Mills Auditorium. I frequently come to the Indian reservations of South Dakota. I recently visited the Lower Brule. I speak at a variety of graduations. I'm always moved by the hardship many Indian people experience and the need to create opportunity and jobs on the reservations.

I do want to give a special recognition to Elaine Quiver. My congratulations to you, Elaine, for your excellent work. When I called Tim Giago of the Lakota Times to get suggestions for witnesses, you were the first name he suggested. And we're very glad to have you here. I have a flag that's been flown over the U.S. Capitol I'd like to present to you. This U.S. flag was flown over the U.S. Capitol on July 18, 1988, at my request. It's a beautiful flag. Can you pronounce that word for me?

Ms. QUIVER. Okachop.

I'd like to acknowledge this presentation to the Foster Grandparent Program. I think it's kind of—I didn't expect this, so I'm not prepared for a speech. But I'd like to have all the elderly stand, because I think this is symbolic, that you all have earned this together, I know there is a lot of elderly here. And thank you very much for your presentation. Thank you very much.

Mr. PRESSLER. Thank you very, very much. Very shortly I will be going out to the airport on one of the buses provided by the Foster Grandparent Program to catch my plane.

However, I want to yield for one minute to a group that would like to talk about a project for the elderly in Rapid City. Do you have a short presentation, or would you rather submit testimony. Why don't you come forward? Let me say I agree with your position. I've already announced that and have sent a letter on your behalf to the General Accounting Office. Now I'd like to hear from you.

Please identify yourself.

TESTIMONY OF CECELIA MONTGOMERY, WA WO KIYE OS-PIYEA ELDERLY PROGRAM, RAPID CITY, SD

Ms. MONTGOMERY. Senator, at this time I would like to express my thanks for giving me the opportunity to say a few words.

And I am Cecelia Montgomery from the Wa Wo Kiye Os-piyea Elderly Program in Rapid City. And I represent—I and two others that came with me, we represent this Wa Wo Kiye Os-piyea group,

formed in 1984. And the purpose of this was to start the aging group in Rapid City so that we could work together and start an elderly building complex on the Sioux San land. At that time, this land was still available, and that was in 1984 when we started.

We have a membership of about 25, 30 people. We have about 15 that are very active. And I would like to come right to the point. Perhaps many of you have been reading the papers, in the Lakota Times and the Rapid City Journal, word that land was put up by GSA for bids on this certain land that we needed. It was in the Journal on June 16, I believe.

And so we went directly to the city and met with Bonnie Hughes because they had the first option to buy that land. And Bonnie came right out and told us, briefly, she said, "Cecelia we don't have no use for that land. If you need support to get an elderly complex on there, we will sure support you. And I will call the GSA right now and see why they put that up for sale if you people had already paid for it."

I have papers here showing that we have written letters to the Aberdeen area office. We wrote to Terrence Sloan on October 16, 1987, requesting that the members of the Wa Wo Kiye Os-piyea would like this location because of the proximity to the Sioux San Hospital and the availability and excee to Federal land. That was our first letter.

On December 17, we wrote to Terrence Sloan again. We send him $1 to put claim on that piece of land. And I have here the copy that we did pay $1 on that land so we could put a hold on it.

And if this land was surplus since 1985 from what we found out when Bonnie Hughes told us, then why didn't the Aberdeen area office have the heart to tell us elderly that we had already lost it then. But they did not tell us until we saw it in the paper.

Then I got a letter back from Aberdeen Area Indian Health Service, a letter in response to the request to purchase excess land in the Indian Hospital in Rapid City. The General Services Administration Office of Real Estate in Forth Worth, TX. They told us to call them and call their attention to this land because they said that it was now up for sale. And if we wanted that land, we had to put in our bid for it.

But do you know something, friends? All of you have elderly from every reservation residing in Rapid City. And why—I'm here today, I'm calling for your support so that we can get this land back to build that elderly complex. We started this, and we're going to hang in there and try to get it. And we don't want to buy it. We want the land because it's Federal land and at one time it was Sioux San Land, and that's Indian land, right?

(Audience response.)

Ms. MONTGOMERY. All right. And that's why we're here today. We need your support from the Gray Eagles, the Sioux Tribes.

I know Iyonne worked with us on this. We made several trips to Pierre for the Commission on Aging, and we got resolutions from other different reservations for their support to get this going. But somehow or other, I don't like to say this, but because we're Indian, we fell through the cracks. And now they have it up for sale. So that's what we would like to stop. And we do need money

to get this complex going. If we can't hit up H.U.D., we'll be hitting other areas.

And also, we need your support so we can get this aging complex going for the disabled, all those who are in need of housing. And we are talking about housing. So that's one thing that we need in Rapid City. And I hope that you will go home and put it down in writing Aberdeen don't have anything to do with it anymore is what I found. It's General Services Administration has gotten ahold of this now. So that's who we have to battle with.

So again, I need your support. And think of all the elderly we have in Rapid City from all these different reservations. After all, they are our Indian people. Thank you.

Mr. PRESSLER. This hearing is concluded. Thank you.

APPENDIX

Item 1

HOMECARE™

NATIONAL ASSOCIATION FOR HOME CARE
519 C STREET, N.E., STANTON PARK
WASHINGTON, D.C. 20002
(202) 547-7424

MARGARET J. CUSHMAN
CHAIRMAN OF THE BOARD
VAL J. HALAMANDARIS
PRESIDENT

HONORABLE FRANK E. MOSS
SENIOR COUNSEL

STATEMENT

OF THE

NATIONAL ASSOCIATION FOR HOME CARE

SUBMITTED TO

THE SENATE SPECIAL COMMITTEE ON AGING

ON

"THE AMERICAN INDIAN ELDERLY: THE FORGOTTEN POPULATION"

The National Association for Home Care (NAHC) is the nation's largest professional association representing the interests of home care providers, homemaker-home health aide organizations and hospices. NAHC is committed to assuring the availability of humane, cost-effective, high quality home care services to all who require them.

We in the home care field are pleased to participate in this effort to focus on the issue of the needs of the American Indian elderly in a community setting. We would like to commend Senator Pressler for holding this hearing to examine this vital issue.

Approximately 75% of the federally recognized Indian Reservations do not have the Medicare home health care benefit available to the elderly Indian population. This basically means that there are no Medicare benefits such as skilled nursing care, physical therapy, speech therapy, occupational therapy and home health aide care available. Further, Medicaid benefits are not available because they quite often are part of an organized home care program, which is not available on the reservation. There appears to be a combination of factors which contribute to the lack of home care programs on the reservations. These factors include: the isolation of the reservations from surrounding white communities where there are certified home health agencies; the tribal customs, which may inhibit the elderly Indian person from receiving personal care services from a stranger or non-Indian; the lack of training of reservation personnel in the intricacies of the establishment of a Medicare-certified home health agency, as well as in the billing procedures, coverage issues and methods of integrating these services into current delivery systems.

Currently there is a community-based Tribal outreach health care program that is staffed by well-trained medically-guided paraprofessionals. This program is found on 250 federally recognized Indian reservations and is called the Community Health Representative (CHR) Program. The CHR Program provides services in the areas of general health care, dental care, gerontological care, maternal/child health, mental health care, environmental health services in the home, hospital/clinic services and community care.

This program was established in 1968. By 1987, approximately 1400 paraprofessionals were working under this program on the 250 reservations served. The 1400 CHRs made 3,470,364 client contacts in 1987. 13% of the client contacts (451,147) were made in the gerontological health area. 5.9% of all client contacts (204,751) were listed as home health care to all ages of clients. The majority of these contacts were on the few reservations where a home care program had been organized and either integrated into or coordinated with the existing CHR program.

Since 1982 there have been severe cutbacks in federal funding in the CHR program, which seriously limits the program's ability to meet the needs of the elderly Indian on the reservation. In 1982, the program had 2400 paraprofessional workers, as opposed to 1400 CHRs in 1987. Based on the current rate of service delivery, had the same number of CHRs been employed in 1987, there would have been 6,000,000 client contacts provided. This would have increased the home health care visits to approximately 354,000 based on the 5.9% of total visits figure. It should be noted that the national average salary of a CHR is less than $11,000. This significantly impacts the ability to retain CHRs and is yet another area of difficulty in the provision of home care services on the reservation. The recruiting of qualified skilled personnel to provide the supervision of paraprofessionals as well as to provide the skilled care needed in the homes is felt far more severely on the reservations than the physician shortage. There are very few Indian nurses or physicians. Recruitment efforts outside the Indian community quite often bring recent nursing and physician graduates to work out their commitments to the federal government for scholarships and loans. The recent graduate is in the majority of cases inexperienced, especially in the field of home care, and the inexperienced bring inexperienced medicine. There is a large turnover rate among professionals on the reservation, which affects the continuity of care which is greatly lacking on the majority of reservations.

There are also few rehabilitation services available on the reservations. Those most needed to allow the elderly stroke victim to return home are physical therapy and speech therapy. These are virtually unavailable to the Indian elderly. The problem is exacerbated by the fact that there are very few reservations where there is a nursing home or skilled nursing facility. Thus, Indian elderly who can no longer remain in the hospital and have no skilled home care benefits on the reservation are being forced to leave their communities and be placed in nursing homes off the reservation. These placements are often many miles from the reservation, which then severely limits contacts with family and friends.

There appear to be few, if any, organized hospice programs which serve the Indian elderly on the reservations. Many of the older Indian people go to the hospital to die. At or near the time of death the Indian custom is to have the extended family present to be with the dying individual. This is not understood by most hospitals who may see an influx of many Indian people trying to wait with their loved ones. At the same time, it is difficult for the family who doesn't understand why they must abide by the visiting requirements which limit the number of visitors and the times that can be spent with their dying family member.

In isolated cases, the CHR programs have tried to provide some types of hospice care to the dying. This cannot be done during the paid time of the CHR paraprofessional, or all the other services would be neglected during that time. So, the CHR paraprofessional staff have had to volunteer their time after normal work hours to provide the service.

In summary, there is a paucity of hospice and home care services, especially those funded by Medicare and Medicaid, available to the elderly American Indian populations.

NAHC recommends that technical assistance and funding be made available to tribes to help in developing and integrating Medicare and Medicaid home care programs into their current systems. A second recommendation is to restore the CHR program to at least the capacity of service level that was available in 1982.

This would go a long way in improving the health status of American Indian elderly.

Item 2

Testimony Before Honorable Senator Larry Pressler, Oversight Aging Field Hearing, Rapid City, South Dakota, July 21, 1988, by Program Director, California Indian Council On Aging.

Honorable Chairman Larry Pressler, my name is Patrick Renick, Program Director for the California Indian Council on Aging has been in existence for over eight years. Representatives are from 42 tribes and Indian organizations in California. The majority of the eight years have been without adequate funding and through dedication of the Board members, the California Indian Council On Aging has maintained its good standing as a non-profit (501)(3)(C) state of California Corporation. As the Program Director of California Indian Council On Aging, I am requesting the Honorable Senator Larry Pressler, Special Committee on Aging support the amendments to the Older Americans Act of 1984, Public Law 98-459. With California having the largest Native American population in the nation, I would suggest our State merit Oversight Aging Field Hearings because the majority of the Native Americans populations have been effectively excluded from services due to inadequate funding levels and other factors which mitigate against having their needs met.

California Native American Senior Citizens are the most underserved, under-represented, minority group in our State, and maybe the nation. Of the thirty-three (33) Planning and Service Areas (PSAs) designated by the State Department of Aging, each with an area agency responsible for administering programs for the elderly. Our office has identified only three (3) Native American that are represented on Area Aging Boards out of the thirty-three (33) Planning and Service Areas.

The Indian Health Service/California Area Office contracts to eight (8) urban and twenty-one (21) rural tribal health centers. Our uniqueness is that California is 100% contract State, unlike the ten (10) other Indian Health Service Area offices where they have Indian Health Service federally financed and operated Service Units, along with Indian Health Service financed and operated hospitals. California does not have any IHS financed clinic facilities or hospitals. Many of the twenty eight (28) clinics in California do not have comprehensive health care because of inadequate funding or are in the developing stages. The overlaying factor maybe because federal Indian health services were not reinstated to California until 1972, and only a minimal amount of funds provided.

During the termination era in California (1955-1965), some forty one (41) rancherias were terminated from federal trust status, the remaining seventy-six (76) Reservations/Rancherias in trust status received no health benefits from federal Indian Health Service or the State of California.

For over twenty (20¹ years, California Indians received little or no health services, providing treatment to Native Americans senior citizens today is very expensive. Many areas of California have exceeding high rates of diabetes and other congential diseases.

Housing availability for the elderly has been in short supply. Houses the elderly occupy are usually in deteriorating conditions, in some instances homes are isolated from major roadway artries and have no telephones. There are only three (3) Title Six - VI Programs in the entire State of California.

The two federal agencies (BIA-HUD) that have responsibilities for Native American housing does not index elderly housing needs. The State of California even has less statistical information concerning housing needs and availability for Native American Senior citizens. The most health service for Indian elders are under-utilized because of limited access (due to lack of transportation, no telephones, information and resources) lack of outreach on the part of mental health providers, lack of a specialized focus within the Indian Health Service/California Area Office delivery system on gerontological study or geriatric health care, and lack of documented information where they live, housing conditions, status of their health conditions. The failure of service providers and policy makers to design Mental Health Services approaches which are appropriate to the social and cultural setting in which the elders have need of services.

Several of the Tribal Health contractors provide excellent care of the Indian elderly, while several developing Tribal contractors need to develop service programs. The Indian Health Service/California Area Office does not have any master geriatric health care program.

In conclusion, Mr. Chairman, the California Indian Council on Aging is aware that the daily living circumstances of Indian elders pose a continual threat to the ability of Indian elders to maintain a healthy outlook on their daily lives and on their future.

I will quote an article by doctors Spero Manson and Donald Calloway, in their article - Health and Aging Among American Indians, "Growing older presents great difficulties for a sizable segment, perhaps 30% of American aged population. Being Indian and being old intensifies these difficulties, but being an Indian over the age of 75 and living in a rural area may represent being a member of the most discriminated segment of the American society".

I would hope my comments will give the Special Aging Oversight Field Hearing, some ideas for way to improve level of care and communications for the Native American senior citizens in California.

The vast complexities of unresolved Indian issues necessitate's future Oversight Field Hearings in California by the Honorable Larry Pressler.

Thank you, Honorable Senator Larry Pressler for having the California Indian Council On Aging testimony submitted in your Oversight Aging Field Hearing.

Item 3

LEGAL ISSUES OF THE ELDERLY AMERICAN INDIAN

My name is Jane M. Smith and I am the president of the National American Indian Court Clerks Association. I am also the Court administrator for the Colville Confederated Tribes Tribal Court in Northeastern Washington. I was requested to submit written testimony concerning what I believed to be legal problems and issues experienced by elderly Indians.

At the forefront of my concerns is the increase in elderly abuse. We are hearing more and more about parental abuse and elderly abuse. However, very few incidents are being formally reported to either the police or to the Court systems. This raises two questions: Why is it taking place and what can we do to stop or decrease the number of incidents?

I feel that one major factor is the high unemployment rate on reservations. Currently, our reservation is experiencing 60-80% unemployment. Most of the unemployed have no hope of getting jobs due to lack of experience and education. Many that obtain jobs will lose them within the first few months due to alcoholism and its inherent problems. Some are unhappy with their employment due to a low rate of pay and unsatisfactory working conditions. Many times, a person will make more money on public assistance than going to a job every day, especially when you consider gas, insurance, babysitters, etc.

More and more drugs are entering our reservation. We are seeing younger and younger children using drugs. Drugs and alcohol cost money and what easier way to obtain money than to get it from an elderly person who cannot protect him or herself. The fact that the elderly person may be your grandmother or grandfather doesn't make a difference when you are having withdrawal symptoms from alcohol or drugs. The basic fact is they have money and you don't.

We are at a loss as to how to combat this problem. The reasons for not reporting these abuses are varied and many. Parents do not want to get their children into trouble. They would probably end up paying any fine imposed anyway. There is the fear of retaliation. Many hope that tomorrow the abuser will see the light and change. Usually, when the person sobers up he or she will be very apologetic and swear never to do that again. This cycle continues indefinitely until somehow the person gets caught. We send those that do get apprehended to inpatient and outpatient treatment centers for alcohol

and drug abuse. We try mental health counseling. We set up community service work with the elderly in controlled situations to try and educate the offender to respect and learn from these people. We levy fines and incarcerate. It helps a few, but the problem keeps on growing. Until we can increase the self-esteem of our people, we can only bandage the real problem.

Another area that I feel would be of great help to many elderly Indians is a liaison. Most of the elderly Indians know what they want but they do not know how to go about getting it. There are many programs and help for them, but there is also a lot of paperwork and redtape. Many of the older Indians were born at home and may not know their exact age or birthdate. They don't remember where they worked twenty years ago and have no idea if any benefits were paid or not. They don't know what benefits they may qualify for now. They don't know where to begin to find the answers to the questions that are required on the application forms. They may be distrustful of anyone who works directly with the State or their government. They need someone who is somewhat divorced from the buresucracy, but who knows who to talk to, where to go and what to say. Basically, they need a friend. A liaison is someone who they can talk to and not feel embarrassed to ask questions that might seem silly to someone else. The liaison may have "walked" their neighbor through this same redtape and buresucracy last month and therefore is experienced in getting them through the redtape today. The liaison would probably be useful in finding out what the real needs of the elderly are and why they aren't getting them fulfilled.

Many older Indians are raising their grandchildren and need to have legal guardianship over them before receiving medical benefits or public assistance. They don't know what to do or what to ask for. We refer them to attorneys because we cannot legally advise them, but not all of them go. They may feel intimidated or feel that it is just too much work for what little benefits they would be getting. When someone in the system starts explaining the process, I'm sure that it overwhelms many of them and they feel they can't or don't want to go through the hassle. Many don't want to bring their children's problems into Court to explain why they aren't taking care of their own children. Some are afraid that if they do bring their children into court, they may suffer retaliation later on. Worse for many, the parents may

return and take the grandchildren away from them. Then the grandparents suffer the loneliness of being separated from their grandchildren. They may wonder if the parents are abusing the grandchildren or feeding them properly. If they had a liaison, that person might be able to sit down with them and their attorney and explain the whole process slowly and thoroughly in a language they could understand. If it was someone they trusted, they would feel comfortable in asking questions and giving information. Sometimes knowing how to ask a question is better than knowing what question to ask.

I feel that there needs to be more training in how to deal with elderly people in general. I see many times where people are very respectful of the elders at gatherings, but are very rude and impatient when that same person comes into their office. We need to become aware that these people may not hear well, may not see well and may not really understand exactly what is going on. They may be very intelligent otherwise, but the legal system has a way of becoming very confusing very easily. We need to keep remembering that we need to have patience and we should take all the time necessary to help these people resolve their problems.

Many courts do not have adequate access for wheelchair clients or those using walkers. Reserved parking for the handicapped is almost unheard of on many reservations. The chairs and benches in courtrooms are usually very uncomfortable. Most court systems had to make do with what they could rustle up and don't have the funding for "comfortable" furniture. Healthy people get tired and restless, let alone those that are suffering from arthritis or rheumatism.

I would guess that most court personnel are inadequately trained in CPR or basic first aid. Many would not know what to do if someone, elderly or not, had a stroke or heart attack in the Court. Most probably don't have disaster planning. What would happen if a fire started or a gas main broke? What about the little gentleman or lady who has an "accident" while waiting three hours for court? Has anyone made provisions for these types of problems? Probably not. They are probably struggling just trying to make the Court run smoothly for the general population. Those people that need special considerations usually end up in a low priority level. Here is another area where liaisons could be very helpful. If they are aware of these unforseen

problems, they could alert the court personnel to be on the lookout and to be prepared. That alone could save a lot of embarrassment and time for everyone.

There needs to be more interpreters in the Courtroom. Many of the older Indians speak their native tongues. English is a second language to them and often it is still not well spoken or understood. Court personnel need to take the time to make sure these people understand what is going on before proceeding. There needs to be more people who can translate basic legal terms into a native language that makes sense to these people. Even someone that can translate "legalese" into English would be a big help.

I am sure that there are many, many more problems that should be looked into. Guardianships over the elderly, right to die, probate and wills are some that come to mind. These are problems that can't be just thought of off the top of your head and then written down in any sensible manner. There needs to be a lot of research and thought put into a project such as this. I'm very glad that someone is taking the ball and going with it. If ever a few elderly Indians are helped in any way by this project, I would consider this a worthwhile effort. If I can be of any further assistance to you, please contact me and I will do my utmost to help in any way possible. Thank you for your time and consideration of my written testimony.

Jane M. Smith
President, NAICCA
Court Administrator, CCT

Item 4

Testimony

of

Steve R. Wilson, Chairman
The National Title VI Grantees Association

The American Indian Elderly: The Forgotten Population

Senator Pressler: I want to take this opportunity to express our gratitude for this Field Hearing that will give us an opportunity to bring to this committee the problems the Title VI Grantees have experienced in trying to bring a much needed and deserving service to a much deserving population - Our Indian Elderly of this great country.

Field Hearings in 1986 in Oklahoma City, Oklahoma, and Santa Fe, New Mexico conducted by the Honorable Senator Don Nickles, OKLA. and Senator Bingaman, N.M., brought frustrations of Indian Elderly advocates to the forefront. Subsequent testimony presented at hearings in Washington, D.C. in 1988 again contained our dreams of changing the plight of the Indian Elderly; but again we met frustration due to the lack of funding increases for Title VI and continued insensitivity on the part of the Administration on Aging.

HISTORY OF TITLE VI

In 1978 Title VI became an Amendment to the Older Americans Act that would provide direct funding to the federally recognized Tribes. It was not until 1980 that funding was approved for Title VI at $6 million. Dreams of establishing comprehensive services to the Indian Elderly population were not forthcoming by the original 83 grantees. Funding levels for the large tribes with large numbers of elderly was a maximum of $100,000 and funding for the smaller tribes staircased downward from that level.

In 1984 the original 83 grantees experienced a cut in funding ranging up to $20,000 for some grantees due to the Administration adding 42 new grantees. Wewere glad to see our brothers receive this funding but not at the expense of the original grantees.

Many of the 83 original grantees had to cut back on the limited services they were providing before the cut in funding. The grantees had to cut down on the days they served meals from

5 to 4 days and even to 3 days. Many homebound meals, chore services and transportation were either cut back or entirely eliminated.

Due to the regulations that stated "Title VI Participants could not participate in Title III programs", this prohibited any state programs from assisting in any way; although we didn't expect this from the States in the first place. If the State Title III programs had been sensitive to the special needs of the Indian elderly and were serving them we would not have gone after any amendments to the Older Americans Act.

This brings us up to the recently passed Reauthorization of the Older Americans Act, 1987. As you know, there is more language in this bill identifying the American Indian Elderly and the targeting of minorities or those with the most economic need.

When we drafted this legislation, we felt that just maybe, we could see a significant change in the on-going Title VI programs and outher Titles of the Older Americans Act and in the attitudes of State programs and a more cooperative effort between the Tribes and states.

REAUTHORIZATION OF THE OLDER AMERICANS ACT - 1987

In the past years the Title VI Grantees were faced with policies and administrative decisions that created a misunderstanding and hardships on our programs. If you were administering a Title VI Program, you would get the impression that nobody cared for Title VI (except the Indians) and that it would go away. We could not get any leadership from the Commissioner on Aging in developing or spearheading the National Indian Aging Policy approved by the 1986 National Indian Conference on Aging in Phoenix, Arizona (see attachment). Therefore, we approached members from the House and Senate sub-Committee on Aging to draft this Policy into a legislative bill which was attached as amendments to the Older Americans Act and approved by the Senate 98-0.

ASSOCIATE COMMISSIONER ON NATIVE AMERICAN PROGRAMS

With the insensitivity toward Title VI from the Administration on Aging, we felt we needed a position, "Indian Desk", within the administration that would understand the programs and understand the Indian people. We also felt this position should have decision making authority and be staffed by an American Indian. This person would also head up an interagency task force on the needs and ser-

vices for older Native Americans, Alaska Natives and Native Hawaiians.

We received reports that these things we invisioned for this position were not being followed by the Administration. A letter was circulated among several Senators questioning the motives of the Commissioner and submitted to her for an answer. At this date, we haven't heard what her reply will be.

TITLE V - SENIOR EMPLOYMENT

A study conducted by the National Indian Council on Aging shows that the participation of Indians in this program is 1.59% of the total Title V positions allocated nationwide. (see attached report).

In the Reauthorization of the Older Americans Act, language was approved by Congress that an Indian Aging organization be given a contract to implement Title V slots to the Grantees. This was to be if Congress appropriated funds over and above the '87 levels. The appropriations by Congress did not come. Prayerfully, this will be corrected by Congress this year.

TITLE VI- COORDINATION OF SERVICES

Language prohibiting Title VI Participants from using Title III services was eliminated. In drafting this legislation in this manner, we felt that Title VI participants could be included in some of the supportive services enjoyed by others but unable to by Indian elders. The targeting of these in "the most economic needs" and minorities that is in the language of the Older Americans Act has not been implemented at this time.

We do not know how the states are going to address this implementation of the Act. I do know that it is a dilemma for many of them. I attended a National Association of Area Agencies on Aging Board meeting representing the National Title VI Grantees Association and they were asking me.

I do know that when we drafted the legislation, we felt that New Monies appropriated by Congress could be used to implement these new targeting items in the Act. We didn't invision that their funding would be cut. As a matter of fact, we were again frustrated when we learned that Title VI had been cut in funding by 4.25% - more than any other cuts in the Titles of the Act.

These cuts have created more problems for Title VI Grantees throughout the Nation. Any plans by the Grantees for expanding any services were done away with due to lack of funding. Many of

the Indian elderly don't have the financial capabilities to donate like they want to help their programs. Turn over in Title VI Directors has always been a problem. Experienced Directors are being lost, thereby, we are losing their expertise in this area, because they do receive training.

The Grantees are trying to serve their elderly in areas that are considered rural. This creates added cost to the programs, but if these grantees did not serve them, they would not receive any services of the Older Americans Act.

The American Indian Elderly: The Forgotten Population is a good topic for this hearing. They are not forgotten by the Tribal programs and Indian advocates, but by those in decision making positions. People who can make the difference in their lives; Administration on Aging, Indian Health Service and other Federal agencies. Also, Congress. If we had received the approved funding levels, perhaps we could see the difference in their lives by expanding nutrition programs, transportation and other needed services that other elderly of this country are enjoying and benefiting from the Older Americans Act.

Too many Indian Elderly of this country are passing away without receiving one penny of service from the Older Americans Act. The Title VI Grantees are willing to work with state programs if approached. We call upon the Congress of this United States to correct the low funding levels of Title VI by approving appropriations that would enable grantees to plan and implement comprehensive services for their elderly. Maybe one day we can stop calling our Indian Elderly - "The Forgotten Population".

Thank you.

NATIONAL INDIAN AGING POLICY

Section I. Statement of Policy

It shall be the policy of the United States of America, and the Congress of the United States that it has a legal and moral responsibility to ensure that the Indian and Alaskan Native elderly of this country are a vital resource and shall be entitled to all benefits and services available; and that these services and benefits shall be provided in a manner that preserves and restores their dignity, self-respect and cultural identity; and thereby shall reinforce and strengthen the unique tribal-federal relationship that has been established by treaty, by Executive Orders, and by the Constitution and laws of this country.

Section II. Findings

The Congress of the United States finds that the Indian elderly (age 60 years and over, according to the 1980 U.S. Bureau of Census) of this country are:

1. Increasing in population from 64,000 in 1970 to 109,000 in 1980; and it is projected that this population will increase to over 200,000 by 1990; and

2. Unemployed at a rate exceeding 80%; and

3. Living in poverty at a rate of 61% ; and

4. Living eight (8) years less than the general population in terms of life expectancy; and

5. Impacted by the lack of Indian nursing homes (there are currently eight (8) nursing homes on Indian reservations, with a total capacity of 492 beds); and

6. Impacted by the lack of Indian Area Agencies on Aging (there are currently 3 out of a total of 665 Area Agencies on Aging in the nation); and

7. Living in substandard and over-crowded housing; and

8. Receive less than adequate health care; and

9. Are served under Title VI of the Older Americans Act at a rate of less than 25% of the total national Indian elderly population; and

10. Are served under Title III of the Older Americans Act at a rate of less than 1% of the total participants; and

11. Are being physically and mentally abused, affecting an estimated 30% of the nation's Indian elderly population; and

12. Are being excluded from benefits under Social Security at a rate of approximately 57% of the nation's Indian elderly population.

Section III. Policy Statements

Based on the preceeding sections, the Congress of the United States hereby establishes the following policy directives designed to meet the physical and mental health needs of the Indian elderly, their spiritual well-being, their continued involvement and roles within society; and the implementation of a policy that is consistent with, re-affirms and strengthens the concepts of tribal sovereignty and self-determination.

A. Economic Security - the Congress of the United States believes and recognizes that all Indian elderly shall be entitled to incomes that meet their needs and allow them to live in dignity.

B. Long Term Care - Health care delivery systems shall be consistent with unique federal-tribal relationships, tribal sovereignty, tribal values and the continuum of care concept.

C. Physical Well-being - The Congress of the United States believes and recognizes that all Indian elderly shall be entitled to health services that enable them to live healthy, productive and enriched lives.

D. Social Well-being - The Congress of the United States believes and recognizes that all Indian elderly should be entitled to receive supportive services which enable them to remain in their own homes and communities, thus maintaining their culture, dignity and independence.

E. Role of the Elderly in Society - The Congress of the United States believes that all Indian elderly are a vital resource and should be entitled to opportunities to continue contributing to their families, tribes, states and to the preservation of their culture.

F. Education and Training - The Congress of the United States believes and recognizes that, through education and training, Indian tribes will implement effective programs which are conducive to the establishing of a society which is sensitive and responsive to the needs of the American Indian elderly community.

G. Research - The Congress of the United States believes and recognizes that an effective research effort will result in a more informed society and will enable the Indian elderly to live their lives in a dignified and independent environment.

H. Spiritual Well-being - The Congress of the United States believes and recognizes that all Indian elderly people have an inherent right to believe and practice their native religion as a right that enables them to live in harmony with their Creator.

Section IV. National Indian Aging Policy Task Force

THEREFORE, the Congress of the United State hereby establishes a comprehensive, coordinated and systematic policy to ensure its elderly Indian and Alaskan Native citizens are provided services in conformance with the intent of this policy.

FURTHER, to ensure the expeditious development and implementation of this policy, the Congress of the United States hereby directs the Administration on Aging and the Federal Council on Aging to create a National Indian Aging Policy Task Force composed of federal agencies, tribal representatives, national Indian aging organizations, other aging organizations and individuals in the field of aging

whose responsibilities shall include but not be limited to the review of existing rules and regulations, procedures, and statutes, and recommend programmatic modifications and legislative actions.

FURTHER, the Congress of the United States hereby directs the National Indian Aging Policy Task Force to submit a comprehensive report to the Congress on the progress made in implementing these policies, and further, the Congress directs the appropriate House and Senate Committees and Sub-Committees on Aging to serve in a monitoring capacity to ensure the receipt of this report. This report shall be submitted to the Congress not later than December 30, 1987.

ANALYSIS OF TITLE V OF THE OLDER AMERICANS ACT

AND

ITS LIMITED IMPACT ON NATIVE AMERICAN ELDERS

BY

Ken White
Program Specialist

National Indian Council on Aging, Inc.

March 09, 1987

The data is displayed on four charts and is based on four sources:

(a) The June, 1985 Year End Report submitted to the Department of Labor by National Title V Contractors;

(b) The June 30, 1986 Year End Report submitted to the Department of Labor by National Title V Contractors;

(c) The December 31, 1986 Quarterly Progress Report submitted to the Department of Labor by National Title V Contractors;

(d) Information provided directly by National Title V Contractors to NICOA.

1. CHART I COMPARISON OF THE NUMBER AND PERCENTAGE OF NATIONALLY CONTRACTED TITLE V POSITIONS AND SUBCONTRACTORS TO NATIVE AMERICAN TITLE V POSITIONS AND SUBCONTRACTORS

As indicated on Chart I, there were a total of 49,559 Senior Community Service Project positions reported by National Contractors.

Of these, 742 positions are specifically targeted for Indian elders. This represents 1.50% of the total allocation of nationwide positions.

Secondly, through the 8 major contractors there are a total of 437 Senior Community Service Project subcontractors/sponsors/offices nationwide*. Of these, 1 subcontract is specifically targeted to Indian Tribes. This represents .23% of the total subcontractors/sponsors/offices nationwide.

2. CHART II COMPARISONS OF 1985 YEAR END STATISTICS TO 1986 YEAR END STATISTICS RE: NATIONALLY CONTRACTED TITLE V POSITIONS AMONG ETHNIC GROUPS

When comparing data for June, 1985 to June, 1986, figures indicate Native Americans received the lowest number of positions; the lowest percentage of increase among all ethnic groups nationwide.

3. CHART III COMPARISON OF THE NUMBER AND PERCENTAGE OF TOTAL STATE UNIT ON AGING TITLE V POSITIONS TO TOTAL STATE UNIT ON AGING INDIAN TITLE V POSITIONS IN 7 STATES

Data focuses on Title V positions provided by State Units on Aging in 7 states with large Native American populations. The figures indicate there were 69 Indian Title V positions out of 2,173 total Title V positions provided by State Units on Aging in the seven (7) identified states. These 69 Indian Title V positions represent 3.18% of the total number of Title V positions allocated to the 7 State Units on Aging.

4. CHART IV SUMMARY STATISTICS: TITLE V, ALL SOURCES

Data indicates there were 78,963 total Title V Positions nationwide. This figure includes both National Contractors and State Units on Aging Positions for the time period ending June 30, 1986. Based on totals of both sources, there were 1,256 total Indian Title V Positions reported by National Contractors and State Units on Aging. This represents 1.59% of the total number of Title V Positions allocated nationwide.

CHART I

Date MARCH 09, 1987

COMPARISON OF THE NUMBER AND PERCENTAGE OF NATIONALLY CONTRACTED TITLE V POSITIONS and SUBCONTRACTORS TO NATIVE AMERICAN TITLE V POSITIONS and SUBCONTRACTORS

CONTRACTOR	# OF SCSP POSITIONS	# OF SCSP SUBCONTRACTORS	# OF INDIAN SCSP SUBCONTRACTORS	# OF ALLOCATED INDIAN POSITIONS	% OF TOTAL POSITIONS vs INDIAN POSITIONS	% OF TOTAL SUBCONTRACTORS vs INDIAN SUBCONTRACTORS
1) American Association of Retired Persons	7,670	100 offices in	0	66*	.86 %	0 %
2) National Council on Aging	6,015	63	1	119	1.98 %	1.59 %
3) National Council of Senior Citizens	9,764	146	0	78*	.80 %	0 %
4) Green Thumb	16,469	32 unit offices in 43 states	0	340	2.06 %	0 %
5) Asociacion Nacional Pro Personas Mayores	1,628	a) 9 regional offices; b) 4 subgrantees = 13 TOTAL	0	28	1.72 %	0 %
6) National Caucus on the Black Aged	1,794	10 offices in 10 states	0	3*	.17 %	0 %
7) National Urban League	1,946	23 Affiliated offices	0	8*	.41 %	0 %
8) U.S. Forest Service	4,273	40 states*	0*	100*	2.34 %	0 %
TOTALS:	48,559	437 subcontractors/sponsors/offices	1	742	1.50 %	.23 %

SOURCES: (A) * 06/30/86 DOL Year End Report.
(B) 12/31/86 DOL Quarterly Progress Report.
(C) Information provided by National Contractors.

CHART II

Date March 06, 1987

COMPARISONS OF 1985 YEAR END STATISTICS TO
1986 YEAR END STATISTICS RE:
NATIONALLY CONTRACTED TITLE V POSITIONS AMONG ETHNIC GROUPS
Conducted by NICOA, Inc.

JUNE, 1985: 65,807 TOTAL POSITIONS			JUNE, 1986: 66,511 TOTAL POSITIONS			COMPARISONS	
Ethnic Group	# of Positions	% of Total Positions	Ethnic Group	# of Positions	% of Total Positions	Increases/Decreases in Positions from June, 85 - June, 86	% of Increases/ Decreases from June, 85 - June, 86
White	42,937	65.25 %	White	42,896	64.49 %	- 41	- .76 %
Black	14,980	22.76 %	Black	15,306	23.13 %	+ 406	+ .37 %
Hispanic	5,087	7.73 %	Hispanic	5,364	8.06 %	+ 277	+ .33 %
Pacific Asian	1,787	2.72 %	Pacific Asian	1,837	2.76 %	+ 50	+ .04 %
Native American	1,016	1.54 %	Native American	1,028	1.55 %	+ 12	+ .01 %
	65,807	100.00 %		66,511	100.00 %		

SOURCE: Department of Labor Year End Report for 8 National Title V Contractors.

CHART III

Date March 09, 1987

COMPARISON OF THE NUMBER AND PERCENTAGE OF TOTAL STATE UNIT ON AGING TITLE V POSITIONS TO TOTAL STATE UNIT ON AGING INDIAN TITLE V POSITIONS IN 7 STATES

STATE	ADMINISTERED BY	# OF SCSP POSITIONS	# OF ALLOCATED INDIAN POSITIONS	% OF TOTAL POSITIONS vs INDIAN POSITIONS
1) Arizona	Department of Economic Security	355	6	1.69 %
2) California	State Department on Aging	1,026	9	.87 %
3) New Mexico	State Unit on Aging	64	4	6.25 %
4) Oklahoma	JTPA Office	197	14	7.10 %
5) Washington	State Unit on Aging	180	8	4.40 %
6) Minnesota	JTPA Office	301	26	8.63 %
7) Nebraska	State Unit on Aging	50	2	4.00 %
TOTALS:		2,173	69	3.18 %

SOURCE: DOL 06/30/06 DOL Year End Report

CHART IV

Date MARCH 06, 1987

NATIONAL CONTRACTORS June, 1986: 66,511 Total Positions			STATE UNITS ON AGING June, 1986: 12,452 Total Positions			TOTALS (of National Contractors & State Units on Aging) June, 1986: 78,963 Total Positions		
Ethnic Group	# of Positions	% of Total Positions	Ethnic Group	# of Positions	% of Total Positions	Ethnic Group	# of Positions	% of Total Positions
White	42,896	64.49 %	White	7,762	62.34 %	White	50,658	64.15 %
Black	15,386	23.13 %	Black	2,686	21.57 %	Black	18,072	22.89 %
Hispanic	5,364	8.06 %	Hispanic	815	6.55 %	Hispanic	6,179	7.83 %
Pacific Asian	1,837	2.76 %	Pacific Asian	961	7.72 %	Pacific Asian	2,798	3.54 %
Native American	1,028	1.55 %	Native American	228	1.83 %	Native American	1,256	1.59 %
	66,511	100.00 %		12,452	100.00 %		78,963	100.00 %

SOURCE: 06/30/86 Department of Labor Year End Reports for (A) National Contractors; (B) State Units on Aging.

CHART I

Date MARCH 06, 1987

NATIONAL SENIOR COMMUNITY SERVICE PROJECT (TITLE V) PROFILE
Conducted by NICOA, Inc.

CONTRACTOR	# OF SCSP POSITIONS	# OF SCSP SUBCONTRACTORS	# OF INDIAN SCSP SUBCONTRACTORS	# OF ALLOCATED INDIAN POSITIONS	% OF TOTAL POSITIONS vs INDIAN POSITIONS	% OF TOTAL SUBCONTRACTORS vs INDIAN SUBCONTRACTORS
1) American Association of Retired Persons	7,670	110 offices in 33 states	0	66*	.86 %	0 %
2) National Council on Aging	6,015	63	1	119	1.98 %	1.59 %
3) National Council of Senior Citizens	9,764	146	0	78*	.80 %	0 %
4) Green Thumb	16,469	32 unit offices in 43 states	0	340	2.06 %	0 %
5) Asociacion Nacional Pro Personas Mayores	1,628	a) 9 regional offices; b) 4 subgrantees = 13 Total	0	28	1.72 %	0 %
6) National Caucus on the Black Aged	1,794	10 offices in 10 states	0	3*	.17 %	0 %
7) National Urban League	1,946	23 Affiliate Ofcs.	0	8*	.41 %	0 %
8) U.S. Forest Service	4,273	40 states*	0*	100*	2.34 %	0 %
TOTALS:	49,559	437 subcontractors/sponsors/offices	1	742	1.50 %	.23 %

SOURCES: (A) * - Based on 06/30/86 Year End Report.
(B) - All other information, based on 12/31/86 Quarterly Progress Report and information provided by National Contractor.

CHART II

Date March 06, 1987

COMPARISONS OF 1985 YEAR END STATISTICS TO
1986 YEAR END STATISTICS RE:
SCSP POSITIONS AMONG ETHNIC GROUPS
Conducted by NICOA, Inc.

JUNE, 1985: 65,807 TOTAL POSITIONS			JUNE, 1986: 63,712 TOTAL POSITIONS			COMPARISONS	
Ethnic Group	# of Positions	% of Total Positions	Ethnic Group	# of Positions	% of Total Positions	Increases/Decreases in Positions from June, 85 - June, 86	% of Increases/ Decreases for June, 85 - June, 86
White	42,937	65.24 %	White	42,896	67.32 %	- 41	+ 2.08 %
Black	14,980	22.76 %	Black	15,386	23.14 %	+ 406	+ .38 %
Hispanic	5,087	7.73 %	Hispanic	5,364	8.41 %	+ 277	+ .68 %
Pacific Asian	1,787	2.71 %	Pacific Asian	1,837	2.88 %	+ 50	+ .17 %
Native American	1,016	1.54 %	Native American	1,028	1.61 %	+ 12	+ .07 %

SOURCE: Department of Labor Year End Report for 8 National Title V Contractors.

Item 5

Testimony

of

Steve R. Wilson, Chairman
Oklahoma Indian Council on Aging
Manager, Community Research & Development
Administration of the Muscogee (Creek) Nation of Oklahoma

"THE AMERICAN INDIAN ELDERLY - THE FORGOTTEN POPULATION"

Oklahoma Indian Council on Aging

Senator Pressler: I wish to express my gratitude for giving me this opportunity to Express, on behalf of the Oklahoma Indian Council on Aging and our 20,000 Elderly Indians of Oklahoma, the frustrations we have experienced in trying to work with a state that for many years have declined to admit that their are soverign Indian Nations in Oklahoma.

The Oklahoma Indian Council on Aging (OICOA) was formally organized and chartered in 1978 whose members represent thirty-nine (39) Indian Nations in Oklahoma. The members of this council are the tribal leaders themselves or are ap-- pointed by their tribal leaders.

Due to many of our Indian Elderly not participating in state orograms funded by the Older American Act, the Indian Nations met to organize to advocate on behalf of our elderly. Our elderly were counted in th. general -opulation for the state to receive monies, but little was done to encourage Indian participation in their programs.

Many reasons our people didn't participate was mostly to culture barriers, language and many felt out of place. The state programs actually didn't have to recruit Indian participants because they had people on the waiting list to nartic-ipate.

Because of the realtionship the Tribal Governments had with the Federal govern-ment, a move nationwide was implemented to develop legislation that would create a title in the Older American Act which Would fund monies direct to the Tribes from Washington. Thus Title VI was as an amendment to the Older Americans Act.

TITLE VI AND TITLE III

Although the Title VI amendments was passed in 1978, the first Title VI Grants were not awarded until September 30,1980 due to difficulties in developing the regulations.

One of the criterias established was that "Older Indians served by Title VI could not be served by Title III funds." This stipultion drove, even wider, the wedge between the Tribal Grantees and the State's Title III program. Title VI was not funded in such a manner that tribes could not provide comparable comprehensive programs for their elderly.

In Oklahoma, the thirteen (13) original grantees were funded in amounts that would only allow them to establish one nutrition site. Any supportive services were transportation on a limited basis and chore services on a limited basis. We also had to define a certain serice area within our Tribal jurisdictions that we could serve. As an example, the Muscogee (Creek) Nation's service area is on the attached map. As you can see the city of Okmulgee and Morris are within this service area. We served approximately 120 elderly per day of which 60 were home bound deliveries. By designating this service area you can see that much of the Creek Nation was left out of this service area. However, many state project directors thought that because a Tribe received Title VI funds all the Indians of that tribe could not recive Title III services. This misunderstanding by the state's project directors have left many of the Indian elderly out of the system.

A personal experience I have had with a Title III program involved my mother and father. Both of them had surgery, so my mother was unable to cook for them. They lived alone and my nearest family was 65 miles away. I called the Title III program to see if they would deliver meals to them. The project director told me "well, well have to get an intake form on them." Three days later they went to our home and the outreach worker told Mom "This will cost you each day and let us know when you can get around and cook for yourself so we can take you off the program." My mother and father was on the program less than two weeks.

My understanding was that no charge was to be made for services. I know they call it a donation, but to set a certain figure for this "donation" I feel is illegal.

This incident also shows that without adequate funding, the tribes can't provide any supportive services to assist out Indian elderly in time of need, even to those within the service areas, much less to those outside these areas.

Although Indians are citizens of this state and do pay taxes, none of the tribes receive state monies for our programs. All the tribes have provided their own in-kind to make their programs successful.

"MORE THAN BOWS AND ARROWS"

One of the problems we saw with non-Indian organizations and states was they didn't know the inter-workings of the Tribal Governments and their programs. So, the Oklahoma Indian Council on Aging embarked on a two year travel agenda putting a a workshop titled "More Than Bows And Arrows. We traveled to State, Regional and National Conferences trying to educate the non-Indian aging network about the Tribal Governments and about how they may serve the Indian elderly. We were successful in some respect by making aware the needs of the Indian elderly to these providers. We could not, however, get the support of the decision makers who should and could make a difference in the lives of our elderly if they understood them. We were able to

gain the support of many people in the aging network to support our ideas of cooperation.

For example, we asked the National Association of Area Agencies on Aging (N4A) to amend their constitution and by-laws to allow an Indian on their board. Our friends on the board introduced it for us and pushed through the amendment, whereby, we are now represented on their board by the Chairman of the National Title VI Grantees Assoc.

We have also worked closely with the American Association of Retired Persons (AARP) in their minority initiatives that they are promoting today. We have also worked with the American Foundation for the Blind and the National Council on Aging.

Statewide, we have representatives on the Oklahoma Alliance on Aging which is the largest and strongest advocay organization in Oklahoma. The Chairman of the Oklahoma Indian Council on Aging has been on the Governors Special Committee on Aging and most recently been involved in a feasibility study on the reorganization of the Oklahoma State Unit on Aging. Many of the recommendations have been submitted to the Governor and every indications shows that this plan for reorganization will be followed in the near future.

The most successful conference in Oklahoma is the Oklahoma Minority Task Force's State Wide Outreach Conference held yearly which gives the state ourtreach workers an opportunity to learn about how to serve the minority elderly population. The Oklahoma Indian Council on Aging has been a big part of the planning and implementing of the Task Force and its conference.

I mention these things because I want everyone to know that we are not sitting around idle just waiting for Federal monies. We are trying to work with the existing state and local level organizations to better improve their image of the Indian elderly and how they may serve our elderly.

REAUTHORIZATION OF THE OLDERS AMERICANS ACT

The Oklahoma Indian Council on Aging was very much involved in the amendments to the Act that was passed this past year. The Chairman was on the committee made up of Indian advocates nationwide to implement these amendments. We felt that the attitudes of the Administration on Aging and the states were not going to change the way things were or have been, and that we needed to develop this legislation that would enhance the programs for the Indian's programs.

Many of the changes in the Reauthorization such as targeting of minorities and those in the "most economic need" have not come to past. I have not been approached by the State programs on how they would like

to follow these mandates now in the law. Is the problem with the Administration on Aging? Has the Commissioner done all that can be done to assure that the mandates of the law have been fulfilled to the limit? We feel the Commissioner should take the lead role in implementing these mandates.

The coordination of state and tribal programs could be a big difference in the service of our Indian elderly, if they were mandated to follow the law. When we see these changes written and implemented by the states, we do not want "lip service". We want to see that they are following the spirit of the law.

Title V - Senior Employment- would be a big asset to the tribal programs, if we could get a contract to a National Indian Aging Organization as stated in the Reauthorization. This falls into the hands of Congress to see that enough monies is appropriated so that this Indian organization can get a contract.

The cost of implementing a Title VI program far exceeds the amount of funding the tribes are receiving. Many of the programs are established in rural settings so they can serve their elderly. If not for the Title VI programs, many of the Indian elderly would not be receiving any services from the Older Americans Act today. It is because our program people care about serving their elderly who live in isolated locations.

The approved funding levels were not passed by Congress last year for Title VI. Instead we were cut by 4.25% which again puts added hardships on the tribal programs. Services had to be cut againg to many of the homebound, transportation has to be cut to many because of these cuts and other services been done by the tribal programs had to be cut back or eliminated due to these cuts. Many tribal governments cannot pick up the cost no longer available because of these cuts.

One of the greatest losses are the Title VI directors who are being lost to higher paying jobs because their program was cut and the tribe couldn't pay them full time or had to lower their salary. This may sound selfish on my part about the directors, but when stability in a program is threatened then it becomes weak. Many of these directors have gone through training that would make them better for their programs and they have learned to reach out to other agencies and organizations for assistance for their elderly. When they leave then a new director has to learn all over again and the elderly are the ones who suffer while the new director learns the ropes.

In Oklahoma we have twenty-three (23) grantees receiving Title VI and we have gone through thirteen (13) new directors this past year alone. We have come to those tribes' rescue many times trying to keep their programs afloat and helping their new director cope and learn about their program.

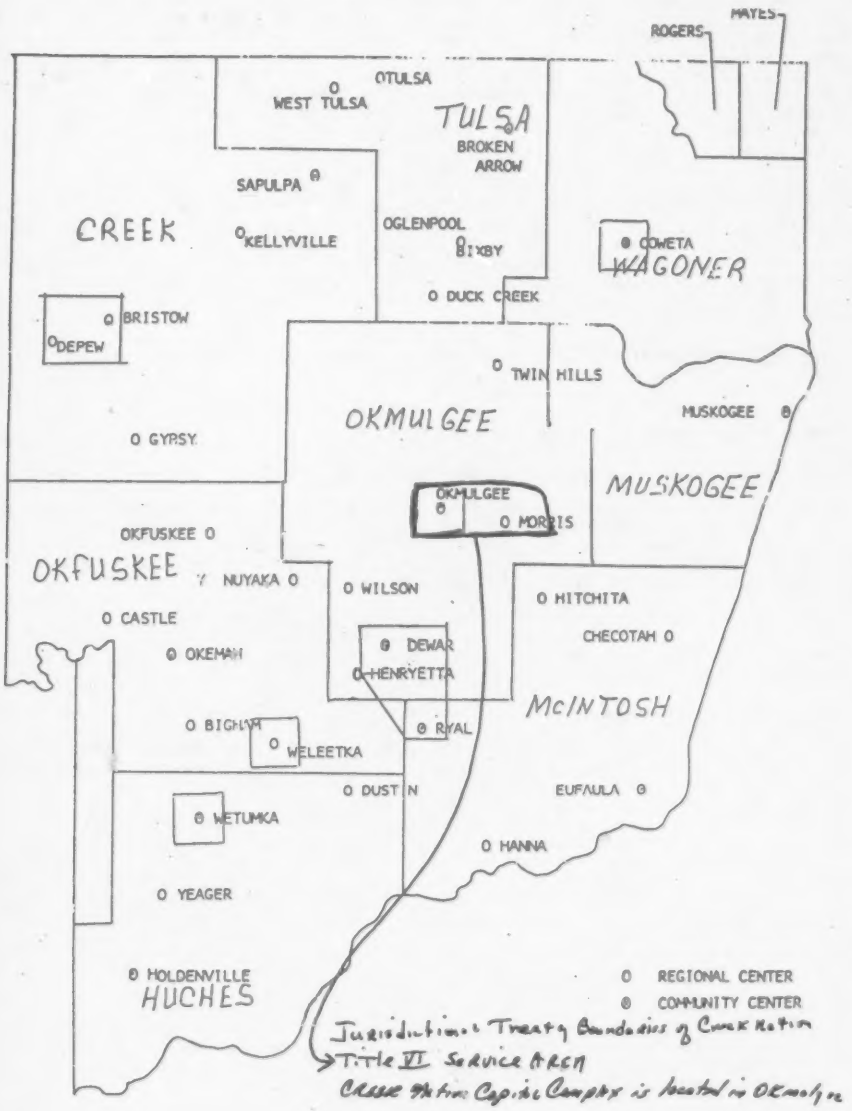
We see the Federal Agency Task Force as a vital part of the Reauthorization because of the chance for changes at the Washington level with all Federal Agencies that would and could make a difference in services to the Indian elderly. We would like for this agency task force to include Indian leaders and Indian organizations so they could have input into any changes. Is this being done?

The Associate Commissioner for American Indian, Alaskan Natives and Hawaiian Natives Aging Programs is a very important part of the Reauthorization. We have not had any success with the Administration on Aging's Policies that have been implemented in the past. Their Policies have hurt our programs in the past and when we have <u>not</u> had any input into these Polocies, its our elderly who get hurt. We felt that the Associate Commissioner for Native American Programs should be staffed by an American Indian froma federally recognized tribe who could and should understand the tribal programs and tribal governments. We felt that with this position fulfilled in this manner, then and only then, when policies are made by the Administration on Aging, we would have an American Indian helping to set these policies. We also would have a focal point within the Administration on Aging that would assist in the implementing of the mandates of the Reauthorization of the Older Americans Act.

As Chairman of the Oklahoma Indian Council on Aging since 1984 and as an Administrator of programs for the Muscogee (Creek) Nation since 1976, I can speak for what is happening in my own state, knowing that as Chairman of the National Title VI Grantees Association, many of these same problems exist in all the states. As program administrators and as advocates for our Indian elderly, we have taken that extra step in trying to work with state programs. We have worked with Congress in developing much of the legislation that was put into the Reauthorization of the Older Americans Act of 1987. Yet, today, we are still crying out on behalf of our Indian elderly, to change the history of Title VI programs to a point of providing adequate, comprehensive services so that our Indian Elderly can enjoy their later years in harmony and pride. It is time to change so that

we can take pride ourselves and stop saying about our Indian elderly, "the Forgotten American."

Thank you again, Senator Pressler and to this Committee for giving me this opportunity to express what I know is going on in Indian Country. I thank you also on behalf of my Indian Elderly for whom I have spoken.



Item 6

NICOA 7/88

STATEMENT OF
CURTIS D. COOK
EXECUTIVE DIRECTOR
NATIONAL INDIAN COUNCIL ON AGING

Mr. Chairman, and distinguished members of the Senate Special Committee on Aging, I want to thank you for the invitation to submit written testimony for your consideration. I especially want to thank Senator Larry Pressler for conducting a field hearing at Pine Ridge, South Dakota, and for having the insight to use this hearing as a means of documenting the fact that American Indian elders are, in many ways, "a forgotten population;" forgotten and neglected by a governmental system that seems to have lost sight of the fact that there are many frail, vulnerable and needy among its own "First Americans."

In the testimony which follows I will show that our government and its policy makers have not only forgotten the needs of the Indian elderly population, but also that it has developed and implemented practices which discriminate against the nearly 200,000[1] American Indian and Alaskan Native elders in our country. I will show that there is an ever-increasing trend toward policies which deny them their rights, and mitigate against the ability of Indian elders to have even their most basic needs met.

I submit, Mr. Chairman, that discrimination and neglect continue and are growing in the procedures being observed by our human service agencies -- in gathering and reporting statistical data, in the establishment and administration of program and Congressional budgets, and in an insensitive public policy. Consider the evidence:

A. Discrimination by Statistical Manipulation:

Some agencies of our federal government are gathering and reporting data in such a way that it effectively discriminates against Indian elders, in that the data obscure the fact that these Indian elders are not being given adequate opportunity to participate in programs which are based on misleading and inaccurate statistics.

The unfortunate outcome of this misrepresentation of the real facts is that services which are supposed to be targeted toward the truly needy are not actually getting to those who need them most. In support of this statement I submit the following:

Bureau of the Census -- The Census of 1980 revealed that 61% of the American Indian elders living on reservations had incomes which were below the national poverty level. Later, in 1986, the Census Bureau "recalculated" their figures and mysteriously arrived at a much lower figure of 33%. Conventional wisdom and first-hand observation of the conditions which prevail on our Indian reservations (with high unemployment, economic suppression, poor housing, etc.) will tell you that the earlier figure of 61% is likely to be much closer to the actual level of poverty. The effect of this radical statistical adjustment, however, remains: programs which are allocated on the basis of these poverty figures are less likely to reach Indian elders.

The Indian Health Service (IHS) -- the Indian Health Service presented testimony at a hearing in Santa Fe, New Mexico in 1986 which was sponsored by Senator Jeff Bingaman when he was a member of the Senate Special Committee on Aging. In the IHS testimony it was stated that "while Indian elders represent only 5% of the total IHS service population, they utilize 18% of the inpatient care resources." This statement was presented as proof that Indian elders receive more than their share of IHS services.

[1] Source: Bureau of Census projections based on the 1980 census figures.

We reject and resent this line of reasoning. Perhaps, it never occurred to IHS policy makers that the 18% utilization figure may have been more reflective of the actual level of need for services, and of the relatively higher costs associated with treating chronic and degenerative illnesses of the elders, than it was an indication that they receive "more than their share" of services. We believe that a resource allocation methodology which is based purely on population and utilization figures such as this is both short-sighted and discriminatory against those who are vulnerable, frail and most in need of health care and services.

Another example of the discrimination which can and does result from the use of misleading statistics may be seen in the recent and questionable adjustments IHS has made in its reported Indian life expectancy figures. Indian life expectancy was reported in 1980 to have been 63.1 years (or about eight years less than that of the general population).[2] However, the Indian Health Service in 1986 reported a rather remarkable and drastic increase in life expectancy to 71.0 years (IHS testimony presented before Senator Bingaman, September 3, 1986). This later figure is being presented by IHS as an indication of their "success" in addressing the health care needs of Indian people, and one cannot help but wonder if this success was what Dr. Everett Rhoades, Director of the Indian Health Service, had in mind when he told a Congressional appropriations committee in 1987 that IHS did not need any more money than was budgeted for the prior fiscal year.

Contrary to the supposed success of the Indian Health Service is a report which was issued by the Senate Special Committee on Aging in 1986 which expressed some rather alarming mortality rates for Indian people as compared to the rates for the general population. Specifically, the report indicated that mortality rates for Indian people from various causes were considerably higher:

--- deaths from alcoholism, 459% higher
--- deaths from tuberculosis, 233% higher
--- deaths from accidents, 155% higher
--- deaths from diabetes, 107% higher
--- deaths from pneumonia, 66% higher

In studies conducted by the National Indian Council on Aging in 1981, 1982, it was found that as high as 40% of the adult population on some reservations had diabetes milletus. In the 1986 study, it was found that as high as 50% of the elders on some Indian reservations were afflicted with crippling arthritis. Other studies reveal an excessively high incidence of hypertensive illness, circulatory problems and other morbidities among Indian elders. More recently, Doctors Spero Manson and Donald Callaway have revealed some very disturbing findings as to the effects of degenerative and chronic illnesses on the quality of life and the mental health of Indian elders.

Mr. Chairman, the above findings clearly indicate that a) the IHS claims of success in Indian health are greatly exaggerated, and b) the Indian Health Service has neglected the needs of Indian elders in its service delivery and budgeting priorities --- witness the existence of specific budgeting categories and programs for women, infants, children and youth; as opposed to the total absence of any gerontological focus or specialized geriatric health care in the IHS service delivery system; and the elimination from the IHS budget of services characteristically needed by the elderly (i.e., eyeglasses, hearing aids, dentures and prosthesis).

The Bureau of Indian Affairs (BIA): -- the BIA, when asked if they have any special programs focusing on the needs of the elders, characteristically answers, "We treat all age groups alike." Consequently, BIA does not keep any statistics on the elders, does not know what their needs are, nor how many elders are in their service population. It is not surprising, then, that there is no BIA initiative or program designed to address the needs of the elders -- unless we consider BIA's burial assistance one which focuses primarily on the elders; in which case, an elder must die to become eligible for this service.

If this is not evidence enough that the BIA is practicing at least passive discrimination, consider the BIA-sponsored policy in its Housing Improvement Program, which requires that an elder "wait his turn" to receive needed repairs on his home, sometimes in spite of the fact that the elder may be living in a life-threatening housing situation. Some elders will not live long enough for "their turn" to come up.

2/ Source: IHS statistics quoted in the Technical Report of the 1981 White House Conference on Aging.

The Administration on Aging (AoA): -- the Administration on Aging has previously reported in testimony before Senator Matsunaga of the Senate Subcommittee on Aging of the Committee on Labor and Human Resources (April, 1987) that 90% of the "eligible" Indian elders are receiving services under title VI of the Older Americans Act (a title which is designed to provide nutrition and supportive services to older American Indians through direct grants to Indian tribes). This claim is being held up as evidence of the amazing "success" of the title VI program, leaving the impression that nearly all Indian elders participate in the program -- but the facts are these:

a) just slightly more than one-fourth (136) of the 504 federally recognized tribes have title VI grants;

b) a nationwide survey of these title VI grantees by the National Indian Council on Aging in 1986 revealed that the grantees are able to serve only an average of 50% of their elders (not 90%) due to lack of funding;

c) putting together the findings in a) and b) above, it is not difficult to calculate the proportion of today's Indian elders who are actually served under title VI: approximately one-eighth of those who are living on the reservations (this does not include Indian elders who are residing in urban areas).

d) the largest Indian tribe in the nation, the Navajo, with a population of more than 25,000 Indian elders, has only two title VI meal sites, serving less than 100 elders each. The remaining elders of the tribe, scattered over at a three-state area, must be served under title III; and these services are actually provided to only a small percentage of the total Navajo elderly population;

e) the second largest Indian tribe in the nation, the Cherokee of Oklahoma, has an elderly population of more than 7,900 spread over a 14-county area. Due to lack of funds, the Cherokee title VI program is able to serve elders in only two (2) of its fourteen (14) counties; or 300 out of a total population of 7900 elders;

f) the previously-mentioned NICOA survey (1986) found that some title VI grantees were serving meals only two or three days per week due to lack of funding. Others were paying program staff only 1/2-time for full-time work, and some sites had to shut down altogether;

g) the Older Americans Act title VI language requires that title VI services be comparable to those provided under title III (i.e., that the grantees provide the full complement of supportive services as well as congregate and home-delivered meals). However, again due to lack of funding, this is not possible for most title VI grantees; and their elders are, therefore, deprived of services mandated under the Act;

h) in 1984, when 43 new title VI grantees were added to the existing total of 83 grantees, the existing grantees experienced cut-backs in funding averaging $20,000 per grantee, further exacerbating an already difficult service delivery budget situation; and

i) of the 673 Area Agencies on Aging in the country (which administer the title III funds) only 9 are operated by Indian tribes. On the other hand, most Area Agencies have not conducted effective outreach and targeting efforts. The unfortunate consequence of this is that far less than 1% of the total title III participants are Indian or Alaskan Native elders.

In summary, then, the statistics reported by the Administration on Aging are both inaccurate and misleading, and services are not being targeted toward Indian elders who are among those who are in the greatest economic and social need -- even though the Congress has been very clear in its intention that Older Americans Act services be so targeted. The supposed "success" of the administration in this area is nothing to crow about.

Taking all of the above into consideration, we contend that the Bureau of Census, the Indian Health Service, the Bureau of Indian Affairs and the Administration on Aging are practicing discrimination by means of statistical manipulation and justification of their failure to address adequately the needs of Indian elders.

Discrimination Via Budgetary Negligence:

Additionally, Mr. Chairman, we submit that Indian elders and their families are being discriminated against by means of the budgetary process, and through inappropriate prioritization of available resources by federal agencies. Whether these practices are intentional or have developed through sheer negligence, they represent de facto discrimination. Consider the following:

a) economic development efforts on Indian reservations over the past several decades have been so minimal that unemployment on some reservations runs as high as 95% of the adult labor force;

b) since 1980, funding for subsidized Indian housing has been reduced by over 70%, although Bureau of Census figures in 1970 and 1980 showed that the vast majority of homes occupied by Indian elders were substandard and generally in need of replacement or repair;

c) since 1980, the Community Health Representatives program which is the primary in-home care service needed most by Indian elders, has been a program which has been targeted by the administration for elimination from the Indian Health Service budget;

d) the Indian Health Service is already employing a highly discriminatory criterion in its resource allocation methodologies -- it is the criterion called "years of productive life lost" (or YPLL). It is the principle by which IHS determines that budgetary resources and service priorities must go to the younger population groups based on the assumption that a younger life lost represents more potential "years of productive life lost." Need I add my own commentary here, Mr. Chairman? I am appalled that our so-called "enlightened society" has so soon outgrown its need for the elders, and that any of us would think for a moment that an elder's life is of less value than that of a younger person. Perhaps, it is no accident that the word "euthanasia" starts which "euth-" (youth). Who will be next? the disabled? the unemployed? the Indians? Whatever happened to "inalienable rights," or "life, liberty and the pursuit of happiness"?

e) the Older Americans Act, which contains the only human services programs in all of the federal budget specifically designed to provide services to Indian elders as a targeted group, has been consistently stripped of its budgetary capability to keep pace with the growing needs of Indian elders, much less the needs of appreciable numbers of Indian elders on reservations and in urban areas across the country. Witness the following budgetary history of the Older Americans Act:

   a) title VI (direct grants to Indian tribes) was introduced into the Act in 1978, 13 years after the original passage of the Act; and it was not funded until 1980, two years after it was authorized;

   b) since 1980, while other programs of the Act were being increased substantially, title VI funding has experienced very minimal increases, and has had to share its resources among increasing numbers of grantees. For example, title III funding has increased by 75% since 1980 with no increase in the ratio of Indian to non-Indian participants (still at less than 1% Indian). At the same time that title III funding has increased by 75% title VI funding has increased by only 25% from $6 million in FY '80 to $7.5 million in FY '87 with a 50% increase in the number of grantees who must share in its limited resources;

   c) as a result of the passage on December 22, 1987 of the Budget Reconciliation Act, funding for title VI (the only Indian specific title in the Act) was reduced by 4.25% (from $7.5 million to $7.181 million), while some of the other programs of the Act were either increased as much as 2.2% or received new monies;

   d) in the pending Senate appropriations bill for Labor, HHS programs in fiscal year 1989, some budget categories are being given substantial increases for relatively less important purposes, while title VI is only being restored to its FY '87 level of $7.5 million, I wish to call your attention to the appropriations for:

      a) the Employment Standards Administration increased by $6,780,000 (purpose: to add 43 FTE staff to the ESA)

b) the Bureau of Labor Statistics
increased by $13,916,000
(purpose: to add 53 FTE staff to the Bureau)

c) title VI of the Older Americans Act
increased by only $319,000
(purposed: to provide nutrition and supportive services to Indian elders).

Somehow, Mr. Chairman, it seems to us that building a bureaucracy with more staff cannot be nearly so important as providing much needed meals and services to at risk Indian elders. This, I believe, is an unfair budgetary practice.

Discrimination Via Public Polciy and Sentiment:

Mr. Chairman, we see developing a very dangerous pattern in our public policy and in some pockets of public sentiment. All the way from the mis-informed statements that our government "humored" the Indians by giving them reservations, to those who would seek to deprive Indian tribes of their rights by "re-negotiating" their treaties, the anti-Indian spirit is having its way with the budget, with treaty rights cases before the courts, and within the administration of human services programs designed to help the truly needy. Discrimination is alive and well in our country -- in Indian country:

-- the day of Gramm-Rudman is the day of the grim Redman;
-- programs most needed by the most needy are being terminated by means of an insensitive budget-cutting mania;
-- the first Americans in many ways, are the last to receive services; look at the reservation quality of life, if you don't believe me;
-- states are disowning any and all responsibility to provide services to Indian people; or they are insisting that Indian tribes waive their sovereign immunity from law suit in order to receive services;
-- and even our Congress is in hasty retreat from any sense of obligation to fulfill the requirements of treaties struck with Indian tribes generations ago. One Senator described to me the mood of the Congress toward Indian treaties with these words: "some in the Congress believe that the only treaty obligation of the government to the Indian tribes is to give to them an acre of land, a horse, a plow, and a blacksmith shop."

It has been said, Mr. Chairman that the true measure of the greatness of a society is not the level of the prosperity of its rich, but rather what it does about the poverty of its poor. Mr. Chairman, please do something about the Indian elders. Please lead us in developing meaningful legislation and strategies for the creation of a caring society around our "respected" Indian elders. I have provided with this testimony a number of suggestions as to how we might go about doing just that, and I would like to have them entered into the record along with this written testimony.

Thank you for your consideration.

Recommendations

1. Increase funding for title VI of the Older Americans Act for fiscal year 1989 by $5 million, bringing the total for FY '89 to $12.5 million. Offsets for this funding may be found in the proposed increases for:

   a) the Employment Standards Administration, being increased by $6,780,000 over fiscal year 1988 in order to add 43 FTE to the present staffing level; and

   b) the Bureau of Labor Statistics, being increased by $13,916,000 over FY '88 funding in order to increase the present staffing level of BLS by 53 FTE.

2. Draft and introduce legislation which will appropriate $5 million to establish an office of gerontology within the Indian Health Service, and to provide specialized training in geriatric health care at each IHS service unit, or to conduct regular geriatric clinics.

3. Draft and introduce legislation which would mandate the development of Indian elderly health promotion and mental health projects.

4. Draft and introduce legislation which will provide in-home care for Indian elders by means of establishment of home health agencies on Indian reservations.

5. Draft and introduce legislation which would fund housing improvement and housing construction programs which will focus on the needs of Indian elders.

6. Draft and introduce legislation which will provide supplemental income support programs for Indian elders who are not now covered by Social Security or SSI.

7. Draft and introduce legislation which will provide health care insurance to Indian elders which can be used to enable them to access IHS or other health care services at levels of participation which are more commensurate with the levels of care they require.

8. Draft and introduce legislation which will provide for the long-term care needs of Indian elders, including in-home, community-based and nursing home care.

9. Conduct oversight hearings on the effectiveness of the Administration on Aging and its network of State and Area Agencies on Aging in providing Older Americans Act services to older Indians.

10. Assure adequate representation of Indian tribes and Indian organizations at the 1991 White House Conference on Aging.

11. Draft and introduce legislation or resolutions which reaffirm the validity of treaties with Indian tribes and which require that both state and federal agencies acknowledge their responsibility to provide services to Indian elders and their families.

12. Conduct oversight hearings dealing with the failure of IHS, BIA and other federal agencies to address the needs of the elders within their service populations.

13. Draft and introduce legislation which will require the Bureau of Census to include the Indian Supplemental Questionnaire in the 1990 Census of the Population in order to assure that statistical information needed for Indian human services programs continues to be available.

Item 7

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF

DR. EVERETT R. RHOADES

DIRECTOR

INDIAN HEALTH SERVICE

Mr. Chairman and Members of the Committee:

I am Dr. Everett R. Rhoades, Director of the Indian Health Service (IHS). I appreciate the opportunity to provide testimony on this important hearing on our American Indian elders.

The Indian Health Service (IHS) is the Federal agency charged with administering the principal health program for American Indians and Alaska Natives. On January 4, 1988, by order of the Secretary of Health and Human Services, the IHS became one of seven agencies of the United States Public Health Service. The goal of the IHS is to raise the health status of American Indian and Alaska Native people to the highest possible level. Its mission is threefold: 1) to provide or assure the availability of high quality, comprehensive, and accessible health services; 2) to provide increasing opportunities for Indians to manage and operate their own health programs; and 3) to serve as a health advocate for Indian people.

With this mission in mind, the IHS is very much concerned with the growing numbers and needs of our American Indian and Alaska Native elders. They represent a very important focal point for the Indian family and cultural traditions of the tribes. This is also the segment of our service population that has the greatest need related to chronic and debilitating conditions.

The Indian population is younger than that of the general United States Population as indicated by the median age comparison from the 1980 Census, i.e., 22.6 versus 30.0. However, the Indian population is aging at an

increasing rate. From 1960 to 1970, the Indian median age increased 1.2 years, from 17.2 years to 18.4 years. From 1970 to 1980, the increase was 4.2 years.

As the Indian population is aging, Indians are beginning to experience at a greater rate those diseases that are associated with an older population. During the period 1975 to 1985, the Indian mortality rate for malignant neoplasms (age-adjusted rate per 100,000 population) increased 21 percent, from 70.4 percent to 84.9 percent. The five leading causes of death for Indians aged 65 years and older in 1983-85 were: 1) diseases of the heart, 2) malignant neoplasms, 3) cerebrovascular diseases, 4) pneumonia and influenza and 5) diabetes mellitus. Older Native Americans are more likely to have more than one chronic disease present than non-Indian elders.

The elderly Indian population is utilizing a relatively high proportion of the health care resources. There were nearly 400,000 outpatient clinical impressions (i.e., reasons for outpatient visits) recorded for patients aged 65 years or older in IHS facilities in FY 1987. This age group accounted for 8.8 percent of all impressions, considerably higher than their percentage of the total Indian population (5.3 percent). Persons aged 65 or older accounted for 8.2 percent of the clinical impressions in FY 1983; the percentage has been steadily rising since then. Diabetes mellitus was the leading specific cause of visits among the 65-and-over age group, while hypertensive disease was the second leading cause.

The elderly Indian population is even a larger consumer, in relative terms, of inpatient services. In FY 1986, Indians aged 65 years and older accounted for 11.6 percent of hospital discharges from IHS hospitals and those hospitals that IHS contracts with. This was over double the percentage they comprise of the total Indian population (5.3 percent). In this age group, the four leading causes of hospitalization in FY 1986 were: 1) circulatory system diseases, 2) respiratory system diseases, 3) digestive system diseases and; 4) genitourinary system diseases.

The IHS is improving coordination with other Federal Agencies with the Administration on Aging (AoA), Health Resources and Services Administration (HRSA), Centers for Disease Control (CDC), National Institutes of Health (NIH) and the Bureau of Indian Affairs (BIA). Memoranda of Agreement have been established with particular emphasis including the special needs of elders. The IHS is emphasizing health promotion and disease prevention (HP/DP)

activities including the elderly and linking with the promotion of scientific and technical activities such as with the National Institute on Aging (NIA) which carries out biomedical social and behavioral research and training on a wide range of issues relevant to the aging process and diseases of the elderly. The IHS also cooperates with the HRSA faculty training fellowship in geriatric medicine and dentistry for a stronger geriatric focus in the clinical disciplines.

The IHS temporarily assigned Dr. J.T. Garrett, Deputy Associate Director, Office of Health Programs to the Commissioner's Office, Administration on Aging as a Special Advisor for Native American elders. This assignment, initiated in March of this year, will be of six months duration and Dr. Garrett will assist the Administration on Aging in the organization and implementation of a newly proposed Office of American Indians, Alaska Natives, and Hawaiian Natives in accordance with amendments to the Older American Act. Activities include awarding grants to tribes for nutritional programs, providing technical assistance, establishing an interagency task force, and conducting Indian studies on Title III and Title VI of the Older American Act with recommendations and reports to Congress. The IHS is proud of this cooperative activity with the Administration on Aging, and we look forward to continued special emphasis on American Indians and Alaska Natives. Currently, joint activities include alcohol and drug prevention initiatives and training of Community Health Representatives for increased sensitivity to aging, debilitating, and limited activity of elders. Planning is underway for jointly sponsored meetings to cross-train AoA as well as IHS/tribal staff for special emphasis on diabetic foot care, alcohol prevention, nutrition, exploring mental health issues of our elders, and special studies for improved services and quality of care and life for Indian elders.

The IHS has placed significant emphasis on health promotion and disease prevention (HP/DP) in all IHS areas. Each IHS Area Office has an HP/DP plan in effect. During FY 1987 a special national conference on health promotion and disease prevention was held in which Tribal leaders and the IHS exchanged ideas and plans for a healthy future, which include the involvement of our Indian elders.

The greatest impact on the overall health status of the American Indian and Alaska Native population will be achieved by promoting healthful life styles, instituting community injury control programs, and continuing the provision of disease prevention services. These advances require a different model of health care delivery than the "traditional" physician-patient relationship and success will be achieved, not by physicians alone, but by the added involvement of health educators, public health officers and nurses, community health workers and traditional native healers. Equally important, success will depend upon the degree to which each community makes a commitment to changing the life style of all its members and to fully include this very important family and culturally related resource - the Indian and Alaska Native elder.

I personally feel and I am confident that most of our IHS staff would agree that providing services to and working with our Indian elders is an honor and a unique opportunity.

Thank you, Mr. Chairman, for allowing the IHS to provide testimony, in hopes that it will bring us all closer together in the best coordination of our efforts in serving our American Indian and Alaska Native elders so that they may have a good and healthful quality of life.

Item 8

South Dakota

Department of Social Services
OFFICE OF FIELD MANAGEMENT

OFFICIAL HEARING OF THE SENATE AGING COMMITTEE

"The Indian Elderly"
Betty Mills Hall

Thursday, June 21, 1988 - 10:00 a.m.

The Lakota people face a significant challenge as time marches on. The scope and intensity of human problems on the reservation are nearly indescribable. Conditions are tolerated on the reservation that would send shock waves all the way to the Potomac if it happened off the reservation.

The elderly of the Pine Ridge Reservation are caught in a unique dilemma. Problems associated with transportation, housing, nutrition, medical care, family dysfunction associated with alcohol abuse, and cultural confusion create a crisis-laden atmosphere. Life is extremely complex and demanding for people who should be able to relax and enjoy life during their elder years.

The elderly often are the hub of the family unit. Unci (grandmother) often cares for her takoja (grandchildren) and serves as a primary caregiver for many members of the tiyospaye. Her role is significant and powerful.

Changing values and frustration associated with alcohol abuse, unemployment, substandard housing, and subsistence level incomes result in very complex family dynamics.

The elderly who has generosity ingrained in her being may be a willing victim for financial exploitation by members of her own family who do not understand that generosity is a two way process.

Elderlies who suffer physical abuse may be too embarrassed to share that information with service providers who could help.

Elderlies may tire of the bureaucratic process involved in getting a response to problems. The jurisdictional maze on the reservation would frustrate the most patient person.

Elderlies who have traditional values must suffer the most intense pain when they are not shown respect by their own families and other Lakota people of younger generations.

The Lakota elderly may be the most valuable resource of the Lakota people. The traditional values of generosity, bravery, respect and kindness, are ingrained in them and could provide a solid foundation for a future of hope for the Lakota Nation.

Traditional values are just as vital to the Indian of today as they were to the Indians who lived successfully in the challenging environment of 100 years ago.

The grandma's were taught those time-tested values by their tiyospayes. They are the link to the proud past of the Lakota people. The transfer of values to subsequent generations has been disrupted by alcohol abuse, family dysfunction and negative intervention including boarding schools, foster care, and related action that inhibits the natural process that transfers and cultivates values essential to a positive quality of life.

What happens when the Grandmas are gone?

Respectfully submitted by;

James West, Social Worker
Department of Social Services/Adult Services and Aging

Item 9

American College of Health Care Administrators

July 15, 1988

Senator Larry Pressler
United States Senate
Special Committe on Aging
Washington, D.C. 20510-6400

Dear Senator Pressler:

Thank you for the providing the opportunity for the American College of Health Care Administrators to offer a testimony on behalf of the elderly Native Americans. The College shares in your belief that the older Native Americans are a forgotten minority. It is our hope that the Special Committe on Aging with the help of other interested organizations can overcome the problems facing the American Indian. ACHCA supports the Special Committe on Aging in appealing for the quality care of our elderly Native Americans.

Sincerely,

Richard L. Thorpe
Executive Vice President

THE NEED FOR LONG-TERM CARE AMONG THE NATIVE AMERICANS

The American College of Health Care Administrators has over a quarter-century history of dedication to quality services through competent and caring long-term care administration. The long-term care administration profession is committed to providing comprehensive health, personal, and social services for persons who require various therapeutic, protective, and supervised environments and milieus. ACHCA's mission involves education, research, information dissemination, and accrediting of the professional long-term care administrator. The major focus of the American College of Health Care Administrators is on quality assurance activities that enhance the knowledge and skills of professional administrators and assure quality care and quality of life for nursing home patients and residents.

Quality health-care should be available for all Americans. Now it is time to focus our attention to the quality of helath-care that Native Americans are receiving. An increasing concern is the availablility of long-term care for Native

Americans. In 1980 the Native Americans over age 65 numbered 109,000. By the year 1990, the number of older American Indians is estimated to be more than 200,000 (National Indian Council on Aging, Inc.). The need for long-term care is here and with the estimated population growth, today's need may become tomorrow's crisis. According to a study done in 1975 by Shannas and Tobin it was determined that 4,150 elderly Native Americans receive long-term care. We are caring for only 10% of the Native American population on their homeland. This segment of the aged population is continuing to grow faster than any other group. In 1960 the average life expectancy of the Native American was 44; today it is 65 years (Westbrook, 1986), a significant increase compaired to the remaining population. The general life expectancy in the United States has also risen slightly, from 72 to 73.3 years. The need is here - we must provide long-term care to the Native Americans.

Today there are nine nursing homes located on reservations. These nine homes provide care for 410 people (National Indian Council on Aging, Inc.). Nursing homes are needed on the Native Americans reservations, due to the fact that the majority of the older American Indian population lives on one of the 600 reservations. Quality health care is not easily accessed, often because of geographic distance. Some reservations are less than one acre, others extend over 14 million acres. Therefore, many reservations are isolated, making it difficult to transport those who need health-care. Increasing the number of nursing homes on reservations would solve the problem of transportation and provide comfort to the aged in their own environment, an environment that is familiar.

Native Americans have distinctive health-care needs. Common ailments are tuberculosis, diabetes, liver disease, kidney disease, hearing impairment, and sight impairment (Westbrook,1986). These health-care needs are slightly different than that of the general population, whose most common ailments osteoarthritis, diabetes, and angina. The physical needs of the Native American are slightly different, however the psychosocial needs are tremendously different.

The obligation we have to the Native American goes beyond simply providing health-care. We must sensitize ourselves to the special needs of American Indians and address the problems that they face. There are a number of ethnic, cultural, and social barriers that must be overcome to provide quality care to the Native American. For example, the Native Americans are traditionally less educated than the remaining population; 29% of the American Indian population has had less than four years of educational training. Malnutrition is also a great problem faced by the Native American. Often malnutrition is the result of alcoholism or poverty. Native Americans are the poorest minority; 32% of those over 65 live below the poverty level (American Association of Retired Persons). Making quality long-term health care accessible by establishing facilities on reservations goes beyond providing for the physical needs of the elderly, it includes providing for the psychosocial needs that many Native Americans have.

Native Americans have a strong sense of ethnicity. They have struggled to remain a distinct cultural group. Indian reservations and the regulations governing those reservations exemplify their desire and need to remain independent and distinct.

Establishing and maintaining long-term care facilities on Native American reservations is a positive means of keeping the Native American culture alive. The elderly Native American depends greatly on his or her family and community. Keeping families together is one of the benefits of nursing homes located on reservations. Visits from friends and family to off-reservation nursing homes are difficult because of transportation problems; cars are rare on reservations and public transportation is often not dependable or accessible. As a result of the lack of company and companionship the aged often feel isolated and lonely. This isolation and loneliness in many cases has resulted in severe shock that results in premature death. Premature death is common for newly institutionalized Native Americans.

The creation of long-term care facilities on reservations affords many possibilities for growth to the Native American

community. The elderly Native Americans are the most respected members of the community; they know the history and folklore of their culture. It is the responsibility of the elderly to pass on their knowledge and wisdom to the younger generations. Facilities on reservations would allow for the exchange of information between generations and possibly act as community centers.

It is the goal of every long-term care facility to give patients quality care and ensure quality of life. Providing quality of life includes providing for the special services and needs of the patient, including orienting the staff to the patients' cultural beliefs and practices. It is important to identify religious values, nutrition and eating habits, vocabulary, and history.

There are over 500 different Native American tribes, speaking 250 different languages and living on 600 different reservations (Stitelman, 1982). Each tribe has its own values, traditions, and beliefs; it would be unfair to assume that one type of long-term care facility would be appropriate for all tribes. Each reservation needing a long-term care facility should identify its unique needs. Facilities can then be constructed and administrated with consideration to these traditions and needs.

Long-term care facilities on reservations allow for more than a comfortable, familiar environment for the elderly, and a place to share Native American culture. It would also create employment for the younger Native Americans. For example, the construction and maintenance of the facility, and care of the elderly, would include the work of younger American Indians. Many Native Americans on reservations are forced to leave the reservation to find employment. The long-term care industry could provide the employment they need to stay on the reservation and preserve their culture. Native Americans have always been an extremely ethnocentric group; long-term care facilities would cater to their desire to remain ethnocentric. The Native American culture is the culture of our land it is our obligation and responsibility to help the Native Americans preserve their heritage.

The American College of Health Care Administrators stands ready to assist in the professional development of Native American administrators through education, research, professional achievement, and a code of ethics. The mission of the college is to assure the quality care and quality of life for all nursing home residents and patients.

Item 10

AMERICAN INDIAN ELDERLY: MENTAL HEALTH STATUS AND SERVICE NEEDS

Spero M. Manson, Ph.D.
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Mental Health Research
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Health problems play a large role in the lives of older American Indians (Schulz & Manson, 1984). For example, 73% of the elderly Indian population is estimated to be mildly to totally impaired in their ability to cope with the basics of daily living (National Indian Council on Aging, 1981). Forty percent of all adult Indians have some form of disability (Indian Health Service, 1978). Liver and gall bladder disease, rheumatoid arthritis, and diabetes also occur far more frequently within this special population than in any other (Sievers & Fisher, 1981). Other health problems include obesity, hypertension, pneumonia, poor vision, and dental decay (West, 1974). The impact of these diseases is reflected in the significantly higher rates of depression among Indian elderly when compared to non-Indian elderly (National Indian Council on Aging, 1981; General Accounting Office, 1977). The physical as well as psychological consequences contribute substantially to the decreased longevity of this special population when compared to Whites (Hill & Spector, 1971; Sievers & Fishers, 1981; Manson & Callaway, in press).

One can continue to list the health-related problems facing older American Indians and Alaska Natives. Indeed, four recent publications detail their excess morbidity and mortality and, in turn, disparity when compared to Whites as well as other ethnic minorities. These publications include: (1) Indian Health Care (1986) released by the Office of Technology Assessment; (2) Report of the Secretary's Task Force on Black and Minority Health (1985); (3) Bridging the Gap: Report on the Task Force on Parity of Indian Health Services (1986) and its companion Indian Health Conditions (1986), and (4) Health and Behavior Among American Indians and Alaska Natives: A Research Agenda for the Biobehavioral Sciences (Manson & Dinges, 1988). However, the most telling example is embodied in the following case study recounted by Manson and Callaway (1988):

B.H. is an elderly Navajo man suffering from Parkinson's disease. B.H. lives with his wife of 40 years in a one room earth covered hogan without electricity or running water. B.H.'s wife suffers from severe arthritis in her legs and can not walk even with the aids of a walker. A wheelchair would be of no use to her as the sand and mud (during the rainy season) surrounding her hogan would not support the narrow gauge wheels of a wheelchair and she would become stuck within several yards of leaving her hogan. B.H. also has great difficulty getting around. He usually spends most of the day sitting in a very worn easy chair, alert except for short periods following the administration of his medication. Tremors and weakness in his extremities make it very difficult for him to accomplish even the most simple chores, e.g. carrying drinking water inside from barrels stored outside the hogan.

B.H. and his wife could not care for themselves were it not for three important factors. A Tribal Home Care Program pays their daughter-in-law minimum wage to spend four hours a day with them, helping with cooking, washing and other chores. The daughter-in-law, even though she lives two miles away, would probably provide these services for free. However, the income she earns from this program is critical in keeping her family's pickup running. Her husband, B.H.'s son, has worked only four months during the last year. His sporadic wage income, his wife's meager salary and contributions from his parents (whose combined income is about $500/month) help support him, his wife and their four children. In return, the son's services are critical to the support of his parents. He hauls wood for fuel and water for drinking, cooking and bathing. He contributes meat from his wife's small herd to his parent's diet (prohibitively expensive otherwise). He also provides critical transportation to a hospital some 45 miles from their residence. At least once a week he takes his parents on an outing to the Trading Post where they socialize and purchase necessities.

Both of his parent's degenerative illnesses are monitored by a Community Health Representative (CHR) who takes vital signs, delivers medicine and tries to anticipate any acute episode. During the last three years due to federal budget cuts the Navajo Tribe has lost over $100 million dollars in revenue. Further funding for CHR's and Home Health Care are problematic. In addition, the Indian health Service (IHS) has cut its field health staff in half, doubling the area of responsibility for the remaining staff. The reservation economy is extremely bleak. B.H.'s son must compete for wage employment in an environment of 65% unemployment - although the Census would count him as being employed because he had some employment during the 12 month reference year.

B.H. and his wife's diseases will become progressively worse but it is doubtful whether he or his wife would accede to being placed in a nursing home. However, if they were placed in such an institution it is clear that outlays paid for their support by the federal government would be 20 to 40 times the amount now being spent to support their portion of the CHR and Home Health Care programs.

These situations find their parallels in our cities as well. Examples of which will be brought to your attention later this morning.

One expects that the mental health consequences of these circumstances are considerable. Little has been done, however, to

demonstrate how such deprivation translates into emotional and mental problems or low levels of morale and life satisfaction among older American Indians. Only six studies have been published which address this topic. They are essentially regional and focus on specific aspects of the stress, illness, and coping process. Nonetheless, these efforts provide some insight into the nature and magnitude of the problem.

In 1980, I and several colleagues (Manson, in press) studied the daily problems faced by 231 older Indians living in two Pacific Northwest reservations and in a nearby city. Our findings indicated that certain types of problems--particularly physical illness and resulting limitations on activities of daily living--occur with alarming frequency among these individuals, resist solution in terms of the social, economic, and psychological resources available to them, and, consequently, engender high levels of persistent stress. The vast majority of these older adults were unaware of potentially appropriate services, did not know how to seek information about needed care, and expressed concern about what people might think of them if they did seek such help. Over 80% of this sample had seen a primary health care provider within the month prior to interview. Slightly less than 10% of those experiencing significant stress due to physical health problems reported that their providers had inquired about their emotional well-being; only 3% were offered specific information about supportive services. Clear urban/rural differences emerged, revealing that the older American Indians who lived in the city were even more disadvantaged than their reservation counterparts.

More recently, I and my colleagues have been annually interviewing 320 older members of four Pacific Northwest reservations about various aspects of their mental and physical health status. These individuals were originally selected because they had been seen for the first time in a local health clinic during the 1984 calendar year for one of three chronic physical health problems: rheumatoid arthritis, diabetes, and ischemic heart disease. Using a widely accepted screening tool, over 32% of these individuals were deemed to be suffering from clinically significant levels of depressive symptoms, more than twice the rates reported by recent studies of older Whites with similar

types of physical illnesses. Subsequent medical chart reviews indicated that less than 7% of their primary care providers--physicians and community health nurses--had observed (or at least documented) these symptoms. Their reported life satisfaction was similarly low: again with little apparent recognition by providers. There also is a strong relationship among these depressive symptoms, low life satisfaction, and ability to perform activities of daily living. It is not too surprising, then, that they are generally dissatisfied with the nature of the health care available to them.

Several years ago, we conducted another study among a small number (n=104) of primary care providers who serve American Indians in two western states. Our focus was on attitudes toward and perceptions of long-term care. Their definitions of long-term care almost invariably centered around institutionalization: 81% (n=84) of them named nursing homes as the only or primary service setting. Furthermore, when asked about the service objectives of long-term care, the vast majority of these providers emphasized rehabilitation and protection, seldom prevention or prolonged longevity. Lastly, in response to the degree to which long-term care is concerned with enhancing patient status, the respondents invariably selected physical functioning and rarely noted psychological or social functioning.

Unfortunately, our recognition and understanding of these problems has been slow to mature in light of extensive documented need. Considerable programmatic emphasis has been placed upon identifying and intervening in similar circumstances among the elderly in the general population. New preventive and promotive technologies have resulted. Yet little of this has found its way to Indian and Native communities. A concerted effort should be undertaken to ameliorate the physical and psychological disabilities that plague older American Indians, to lessen the crushing burden that their illnesses place on already stressed family care-givers, and to assist local communities in developing innovative responses to the ensuing needs.

Item 11

Testimony Submitted

by

Theodore H. Koff, Ed.D.
Kristine Bursac, M.P.A.
Arizona Long Term Care Gerontology Center
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LONG TERM CARE AND NATIVE AMERICANS

Many variables will impact the future use of long term care services by the Native American elderly population. Projections regarding the future demand for long term care services should address not only demographic shifts in the age of the Native American population, but also trends in mortality, stability of social supports, functional status and technological advances over time.

Current Status of the Elderly American Indian

Between 1970 and 1980, the number of elderly American Indians 60+ has increased by 73%, from 63,000 to 109,000. It is expected that this number will reach over 200,000 by 1990. In the last 10 years, the life expectancy of Native Americans has increased by about six years which is almost identical for that of all races in the United States. The incidence of chronic illness and the need for health and social support services increase with age. Chronic illness is found among 50% of the total rural Indian population. Impairment levels of American Indians 55 and older are comparable to non-Indian U.S. elderly 65 and older. Rural Indians 45 and older are comparable to non-Indian elderly 65 and older.* Of major significance are the implications of these trends on the delivery of quality health and social services to elderly Native Americans.

Socioeconomic status of elderly American Indians is significantly worse than that of the general population. Over 69% of Indians 65+ have incomes below the poverty level, as compared with 25% of the general United

*American Indian Elderly: A National Profile. National Indian Council on Aging, 1981, p. 1

States population. This is largely due to high unemployment rates which range from 38-95% for the Indian population. Economic security is a major problem for elderly Indians especially those living on reservation, since few were employed and/or survive long enough to be eligible for pensions, Social Security, Medicare or other federal entitlement programs.

Long Term Care Needs of the Native American Population

A comprehensive long term care system to serve Native American persons in need of chronic care services should be developed to offer a wide range of services and facilities to provide any level of care needed and to have other levels of care available as they may be needed. A continuum of care includes medical as well as social services and ranges from total institutional care such as nursing homes and hospitals to less restrictive services such as home health care, nutrition programs, etc. (American Health Planning Association [n.d.]). The following discussion of long term care services has differentiated between institutional and community-based services only to emphasize the current status and stage of development of these services in tribal communities.

Institutional Services

Today there are a total of eight nursing homes* located on tribal lands throughout the western United States, with a total of approximately 410 beds (see table). Some of the basic needs and problems confronting these facilities and their elderly residents include:

1. The lack of commitment of Indian Health Services, Bureau of Indian Affairs, Medicare and Medicaid regarding long term care for Native Americans. What and how should the various federal agencies begin to coordinate their resources to ensure the availability of long term care facilities on reservations?

2. Existing definitions and determination of level of care (e.g., skilled, intermediate and personal) are inconsistent across federal agencies and are inappropriate to the Indian community (persons needing an intermediate level of care in the Indian community compared to non-Indian communities).

3. Reimbursement for institutional care is inconsistent, slow and fragmented across federal agencies including IHS, BIA and HCFA (Medicare/Medicaid). Who is going to pay for which level of care? How are state and local funds for long term care integrated within the reimbursement profile for institutional residents in on-reservation facilities?

4. Many elderly Indians residing in long term care facilities used the services of medicine men in conjunction with traditional western medicine. However the costs associated with providing this type of care is not reimbursable under Medicare.

*National Indian Council on Aging, 1988

5. Medicaid reimburses long term care facilities based on bed occupancy. If the bed is vacant, it is not reimburseable. Most Indian communities are isolated, making transportation to and from the facilities difficult especially in inclement weather. Consequently many visits away from the facility exceed the maximum allowable days and the long term care facility is not reimbursed for the vacant bed. What can be done to make sure these circumstances as well as other cultural/religious deviation from the norm are considered in reimbursement policies?

6. Many of the professionals and paraprofessional staff working in long term care facilities where elderly Native Americans reside have not been adequately trained in the technical aspects of care, supervisory and management skills as well as in the traditional beliefs, language and diet of residents within the long term care facility. Additional training monies must be made available to update existing skills and introduce new ones for on-reservation nursing home staff.

7. There exists a need for additional on-reservation nursing homes. Facilities on reservations provide a protective environment for recovery after hospitalization, opportunities for employment of younger adults living on the reservation, and a means for helping keep families closer together. Where will the additional funds/resources come from for building or expanding facilities?

8. Initiatives need to be introduced supporting the reexamination of HCFA's cost reimbursement formulas to take into account special circumstances and considerations regarding nursing homes on reservations (e.g., inability to generate revenue from ancillary services and private paying clients, remoteness of facilities from urban centers precludes any investor interests, increases delivery and transportation costs, and creates obstacles which prevent the recruitment of professional licensed personnel; and because of the small size of facilities, construction and operating costs are high, thus creating the need for higher reimbursement levels).

Community-Based and In-Home Services

Currently among the elderly Native American population there exists a higher incidence of chronic illnesses as well as a greater degree of dependence for functional assistance with the activities of daily living than demonstrated by the non-Indian elderly population. As the incidence of chronic illness increases so does the need for health and social support services. In the trajectory of chronic illness there may be a need for many different services offered either for short or long periods of time. Services can be delivered in the person's home, especially when the individual is homebound, or the person may receive services elsewhere. Recognizing this, many tribes are in the process of incorporating comprehensive long term care services within a predominately acute care health delivery system. Special attention and enhanced financial support must be given to the development of these long term care systems to ensure coordination with existing tribal services as well as to create a framework for the future delivery of quality care within a comprehensive health delivery system. Some of the major issues or concerns confronting tribes in the development of community and in-home services are:

1. What and how should various federal, state and local agencies begin to coordinate their resources to ensure the planning, development and availability of long term care alternatives to institutionalization? Who and what kind of technical assistance will be available to tribes to plan and develop a comprehensive long term care delivery system? What federal agency will be responsible for consolidating a set of regulations and procedures (funding and administrative) for aging programs and services, including cultural and traditional considerations?

2. Eligibility standards for community-based long term care services differ depending upon funding source(s) (federal, state or local agencies). Eligibility determinations need to be sensitive to demographics of tribal populations and existing delivery systems. Indians who reside on reservations should be afforded the full range of long term care services available to the non-Indian population.

3. Essential to the appropriate allocation of resources and the provision of quality chronic care services is the development and implementation of tribal functional and social assessment data bases for Native American elderly populations. Assessments should be compatible with the current tribal service delivery systems and be culturally relevant and sensitive to client needs. Tribes and their service providers should be authorized to enter into administrative agreements with the state and federal governments so that assessments are conducted which will insure that appropriate admissions and services are provided to each individual.

4. In order to select and monitor appropriate home and community-based services for elderly Native Americans a case management system must be implemented and coordinated with tribal service providers. Administrative funds (state or federal) must be made available for training and maintaining case management staff.

5. Based on the strong intergenerational ties between Native American family members, opportunities for the continued support and training of informal caregivers must be provided for on-reservation families and friends. Who and what funding sources need to be made available to maintain and strengthen informal support networks on the reservation?

6. A legislative mandate needs to be initiated which would allow the Administration on Aging to coordinate Title III and Title VI of the OAA and provide for the direct flow of federal funds (Title III and Title V) to Indian tribes. Who at the Administration on Aging will be responsible for the administration of this program?

7. Currently there exists a lack of public transportation on the reservations. Most transportation to health, social and recreational services is provided by relatives or friends of the elderly or chronically ill person needing assistance. Additional funding is necessary to enhance the capacities of tribes to provide much needed transportation services.

8. The level of educational attainment of Indian long term care service providers is generally lower than the non-Indian service provider. This is in part due to limited opportunities for education and training programs on the reservation and the lack

of culturally relevant training materials. Efforts need to be initiated for the education and training of Native American long term care services providers, including both initial training curricula to teach basic skills as well as curricula for upgrading knowledge of service delivery and care of the chronically ill Native American. Where and how will additional training funds be generated? Who will be responsible for the design and development of culturally relevant and sensitive training materials.

Summary

It is with great urgency and of utmost importance that policymakers begin to examine and, when appropriate, reexamine the impact of "select" public policies on the delivery and development of long term care services for chronically ill Native Americans. It is essential that a national Indian long term care policy be developed and mandated to ensure the delivery of quality comprehensive care within an environment built on mutual concern, dignity and respect.

Characteristics of Eight Nursing Homes Located on Tribal Lands[1]

Starting Date	Name	Tribe Served	Location	Number of Beds	Types of Beds[2]				Occupancy Rates	Percent Indian Staff
					SNF	INT	PC	Other[3]		
1969	American Indian	Papago/Gila River	Arizona	96	X	X	X	X	100%	83
1971	Chinle	Navajo	Arizona	79		X	X		85-95%	95
1974	Blackfeet	Blackfeet	Montana	49	X	X			69-70%	94
1978	Oneida	Oneida	Wisconsin	50	X	X	X	X	90-92%	71
1978	Toyei	Navajo	Arizona	66			X		90-100%	91
1978	Carl T. Curtis	Omaha	Nebraska	25		X			80-85%	80
1979	White River	Apache	Arizona	20		X			90%[4]	100
1982	Laguna Rainbow	Laguna	New Mexico	25		X			100%	95
Total Beds				410						

[1]A Profile of American Indian Nursing Homes. Arizona Long Term Care Gerontology Center, 1984.

[2]All beds are licensed by the health department of the state in which they are located, except for Toyei and White River.

[3]"Other" includes board and care.

[4]In winter.

Item 12

Idaho Indian Council on Aging

July 13, 1988

Honorable Larry Pressler, Senator
U. S. Senate
Washington, D. C. 20510

Honorable Larry Pressler:

Most Idaho Indian Elderly Nutrition Service Delivery is remote and miles apart from the nutrition sites. Some are divided into districts, for example, the Fort Hall Indian Reservation has five districts and only two are served by the Fort Hall Elderly Nutrition Center. The third district is being served by Title III under the area V. The nearest Nutrition Center to this district (Bannock Creek) is the American Falls Elderly Nutrition Center. This title III Program is contracted to serve the Indian Population in this remote area thru the Pocatello Elderly Nutrition Center. The other two districts do not receive any nutrition service. Both districts are quite a few miles from the Fort Hall Nutrition site.

The Shoshone-Paiute have a small Nutrition Center which is very under funded and under staffed. Their reservation is located in Idaho and Nevada. Their Nutrition Program is under Title VI. The Nez Perce have two Nutrition Centers, one which is located in Lapwai and the other in Kooskie. It is quite a few miles apart. This Nutrition Program is under Title VI and is very under funded.

The Couer d'Alene Tribal Nutrition Center is located in Plummer, Idaho. They have a problem in their funding. They serve only one meal a week and are under staffed and under funded. Their Tribal Business Council will not help in their funding. They are in with three other tribes under Title VI.

Now they have enought qualified members to apply for their own grant. They are now working towards this goal.

We have a communication problems here in Idaho. We have an Idaho Indian Council on aging and we meet quarterly. We have the National Executive Director attend our meetings when available. He offers to us the information on the national level. The Executive Director attends two or three meetings during the year.

Congress appropriated more funding to the Aging program. The appropriations Committee reduced all the grants for the Idaho Tribes under Title VI. We expected an increase in our grant but were cut $7,000.00.

The same with the state programs for the Aging. They never include the tribes into their budgets because we are funded under Title VI.

This is not all the problems of the Idaho Indian Aging programs. The Idaho Tribal programs on aging have more problems than we can deal with concerning housing, health problems, and financial hardships, which includes transportation.

Any advice or any type of assistance from your office or any other department who is willing to offer any type of assistance or information is very much appreciated.

I thank you for your reply.

Sincerely yours,

Hugh Edmo

Hugh Edmo, Chairman
IDAHO INDIAN COUNCIL ON AGING
P. O. Box 306
Fort Hall, Idaho 83203

cc: File (1)

Item 13

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STATEMENT OF
THE NATIONAL SENIOR CITIZENS LAW CENTER

Prepared by
Alfred J. Chiplin, Jr., Esq.
with
Donna Shea, Law Clerk

"THE AMERICAN ELDERLY INDIAN: THE FORGOTTEN POPULATION"

HEARING BEFORE THE
SENATE SPECIAL COMMITTEE ON AGING

July 21, 1988, Pine Ridge, SD

Mr. Chairman and members of the Committee, the National Senior Citizens Law Center (NSCLC) is a national back-up center that assists Legal Services Corporation (LSC) and Older Americans Act (AoA or the Act) funded legal assistance providers across the country in providing legal representation to elderly clients. We appreciate this opportunity to present our views and comments, the focus of which are barriers to services for older indians under the Older Americans Act, 42 U.S.C. §3001, et seq., amended in 1987, P.L. 100-175, 100 Stat. 926 (Nov. 29, 1987).

I coordinate the AoA funded activities of our office and provide technical assistance to legal assistance advocates about the requirements of the Act and its implementing regulations and about AoA policies and guidelines that impact on the delivery of AoA funded legal assistance.

Summary of Testimony

1. Older indians are significantly under-served through AoA resources.

2. Greater outreach efforts are necessary in order to reach older indians.

3. Language and cultural considerations must be part of efforts to target and serve older indians.

4. Legal assistance is an important access service for older indians.

Some twenty-two (22) years after its enactment, and after several reauthorizations, the Act should be an efficient vehicle for addressing the fundamental needs of all of America's aging population. However, the American Indian elderly population is still not receiving assistance appropriate to its numbers.

In the 1987 amendments to the Act, Congress sought to do more to address the needs of older indians by providing for grants to Indian tribes for supportive services and for nutrition programs. Awarding the money and implementing the services, however, pose complicated problems. Methods for reaching older indians, whether through state and area agencies on aging or through other outreach methods are in serious need of development and extension.

Under the guise of "flexibility," the Administration on Aging, the federal agency with responsibility for the overall administration of the Act, has taken the position that it need not provide direction and guidance to state and area agencies on how to extend services to specifically targeted population groups such as older indians. A central problem with this approach is that it leaves a serious gap in leadership, planning, and service delivery. This gap acts as an effective barrier to developing programs and outreach efforts that could make AoA funded supportive services programs (legal assistance, transportation, health promotion, etc) truly available to and viable for older indians.

A critical aspect of developing services for all groups under the AoA is the "state plan." This plan, as is true with the "area agency plan," is to be developed through public participation. State and area agencies are to have a mechanism to obtain and to consider the views of older persons. Sadly, neither the current nor the recently proposed regulations implementing the Act provides guidance for facilitating the the development of such plans. This lack of guidance should prove especially difficult in obtaining the input of the elderly indians. As such, this omission acts as a significant barrier not only to plan development but to the actual receipt of services.

With respect to plan development, there is also the question of language. What language(s) will be used in notices of public hearings on state and area plans? In what language(s) will public hearings be conducted?

Finding the older indian is part of the obligation to target those in greatest social and economic need. This involves convenient access to information and referral services and community center services that take into account cultural and language differences.

While it is true that state and area agencies on aging have not seen the value of legal assistance for the elderly population generally, this oversight is all the more detrimental to older indians as older indians are often the "poorest of the poor." The recognition of legal assistance as an access service along with specific efforts to develop and to implement such services for older indians can function as a tool for addressing discrimination in community services, in public and private housing, in employment, and in educational opportunities for older indians.

It is of vital importance that additional fora such as this one are conducted. It is only when the problems of specific segments of our population are identified and made the focus of in-depth scrutiny that we as a nation begin to act. As a nation, it is imperative that we make the Older Americans Act an Act for all older Americans, including older indians.

Item 14

WRITTEN TESTIMONY PRESENTED BY THE
FEDERAL COUNCIL ON THE AGING FOR INCLUSION IN
RECORD OF HEARING HELD BY SENATOR LARRY PRESSLER
THURSDAY, JULY 21, 1988
ENTITLED: THE AMERICAN INDIAN ELDERLY: THE
FORGOTTEN POPULATION

The Federal Council on the Aging (FCoA) was created in 1973 and is authorized by Section 204 of the Older Americans Act, as amended. The Council is composed of 15 members selected by the President and the Congress. Council members, who are appointed for three-year terms, or continue to serve until they are reappointed or a successor is appointed, represent a cross-section of rural and urban older Americans, national organizations with an interest in aging, business, labor, and the general public. According to the statute, at least nine members must themselves be older individuals.

The President selects the Chairperson of the Council from among the appointed members. The FCoA is mandated to meet quarterly and at the call of the Chairperson.

Functions of the Council include:

- Continuously reviewing and evaluating Federal policies, programs and activities affecting the aging which are conducted or supported by Federal departments and agencies in order to assess their value and impact on the lives of older Americans.
- Serving as spokesperson on behalf of all older Americans by making recommendations to the President, the Secretary of Health and Human Services, the Commissioner on Aging, and to the Congress with respect to Federal policies regarding the aging and federally conducted or assisted programs and other activities relating to or affecting them.
- Informing the public about the problems and needs of the aging by collecting and disseminating information, conducting or commissioning studies and publishing their results, and issuing reports.
- Providing public forums for discussing and publicizing the problems and needs of the aging and obtaining information relating to those needs by holding public hearings and by conducting or sponsoring conferences, workshops and other such meetings.

The Council is required by law to prepare an annual report for the President on the Council's activities and recommendations for the ensuing year.

During its February 1987 meeting, the FCoA approved a recommendation to hold the May meeting in Pierre, South Dakota, with the theme being Methods and Practices for Serving Rural and Native Americans.

Because the testimony, experiences and activities the FCoA members encountered were so meaningful and productive, it was decided to have staff make a compilation of all data pertaining to the May meetings.

This print was distributed to key policy makers in the public and private sectors involved with rural and native American affairs.

Noteworthy among the testimony received from the Cheyenne River Sioux and the Sioux Nation Commission on Aging, Eagle Butte, were the following facts:

1. Nutritional programs among Sioux need careful study because of high incidence of diabetes.
2. Home-health care-delivery to tribal members is in need of native American personnel and added funding.
3. Congregate housing for elderly could be answer on reservations but "Indian way of life" makes it hard to institute.
4. Swing bed program in IHS hospitals would help make up for lack of nursing homes in or near reservations.
5. Tribal councils must take a more enlightened and active part in serving needs of Indian elderly.
6. Health care programs though still inadequate contribute to increasing numbers of Indian elderly though life expectancy of native Americans is <u>still 4 years less</u> than national average.
7. I.H.S. community health representative program works at local levels using tribal members who have had basic health training. Compared to "Chinese barefoot doctors."
8. Rejuvenation of intergenerational bonding (a tribal heritage) is being aided by Foster Grandparent Programs.
9. Less funding for Title VI of OAA by Congress in 1988 inexplicable.
10. Health care of elderly not locally based and often exacerbated by language barrier.
11. Drugs among younger tribal members lead to elder abuse.
12. Dietary linkage between diabetes and surplus commodities.
13. Department of Interior, Bureau of Land Management, spending more on wild horses and burrow care than is appropriated for OAA Title VI. (See below).

The FCoA later in executive session took the following action:

1. It was moved and seconded that staff be authorized to approach proper HHS officials regarding the "swing bed issue" involving the Eagle Butte reservation I.H.S. hospital. Dr. Sloan was thought to be the best South Dakota contact person for IHS input with State Director Vogel to be kept informed of FCoA actions.

2. Council requested staff to obtain Agriculture department information regarding surplus commodities effect on high incidence of diabetes among Sioux tribal population. Could products be selected with this anomoly in mind?

3. Staff was instructed to research transportation initiatives for rural areas which might result in forum on this aspect of services at a future FCoA meeting.

4. Staff was instructed to contact the National Institute on Aging regarding the requests of Dr. Sloan of IHS and Bernie Long, IHS clinician, for data base assistance in formalizing treatment of diabetes among the Sioux people.

5. Members requested staff to provide numbers and funding distribution data regarding increase of eligible tribes effecting Title VI.

6. It was agreed that if the Older Americans Act is amended to allow broader tribal participation in Title III, the ensuing AoA regulations should be monitored carefully.

Members of the FCoA were most distressed by testimony by one witness, Wayne Ducheneaux, Chairman of the Cheyenne River Sioux Tribe. Mr. Ducheneaux pointed out that Congress has appropriated twice as much money for administering the Wild Free-Roaming Horse and Burro Act than for Title VI of the Older Americans Act which provides benefits and services for older native Americans.

Current appropriations reflect exactly the same imbalance.

Thank you Senator Pressler for giving the FCoA this opportunity to present our concerns for the plight of native American elders.

Item 15

YANKTON SIOUX TRIBE
BOX 248
MARTY, SO. DAK., 57361
384-3804 / 384-5687

TO: Senator Larry Pressler
U.S. Senate
Washington, D.C. 20510

FROM: Mr. Darrell E. Drapeau
Elderly Case Management Supervisor
Yankton Sioux Elderly Case Management Services

RE: PREPARED STATEMENT OF DARRELL E. DRAPEAU, YANKTON SIOUX TRIBE ELDERLY CASE MANAGEMENT SERVICES, MARTY, SOUTH DAKOTA

Mr. Pressler, distinguished members of the Senate Aging Committee, interested parties:

I am pleased to submit this statement of our views on the problems, needs, and interests of the Yankton Sioux elderly with the sincere desire that it will impact current nationwide attempts to remedy and thus create an awareness of deficiencies and inadequacies in the treatment of tribal elderly.

The Yankton Sioux Tribe is a small reservation based tribe in southeastern South Dakota. Our population is 5,400 enrolled members with 2,700 living on or near the reservation. One hundred seventy eight of the 2,700 living on or near the reservation are Yankton Sioux elderly.

Within the past two decades, Indian tribes in the United States have made tremendous strides in identifying and protecting the rights, resources, needs, and interests of their people. Tribes are forcefully asserting their water, hunting, and fishing rights; maximizing the economic return from mineral resources; defining the jurisdictional sovereignty of their governments; and expanding the powers of their courts. This same effective advocacy should and can be brought to the protection and assertion of elderly needs and interests. For life the

aforementioned resources, elderly Indian people are an important cultural resource of Indian tribes.

At a public meeting of the Yankton Sioux elderly on July 6, 1983 the concerns of the elderly were many. The consensus was that the most visible problems affecting the general population on this reservation are increased alcohol abuse; increased vandalism of public and private property; lack of interaction and understanding between youth and elderly; and high unemployment. The most visible problems affecting the Yankton Sioux elderly are the lack of Medical Homemaker Services which could assist some elderly to remain in their homes longer thus reducing the need for some to enter nursing homes. This Tribal program could collaborate closely with existing social agencies for the elderly to minimize duplication of services; a Tribal Social Worker designated to work with the elderly would be of special benefit to them; waiting lists have been very long when tribal elderly seek nursing space locally. Some reservations have developed tribally operated nursing homes for their elderly; perhaps this should be explored here on the Yankton Sioux Reservation for those elderly so inclined.

In addition to the foregoing concerns, the Yankton Sioux elderly expressed the following misfortunes befallen them:

1. There is no advocacy program to represent the needs and problems of the elderly to the tribal government.
2. Lack of transportation systems to assist the elderly when the need arises.
3. The elderly are too idle. A program for the elderly could work to remedy this deficiency.
4. There is a need for better police protection in the form of additional police personnel.
5. The housing conditions are nearly helpless, certainly not hopeless, but pretty well pitiful. The Yankton Sioux Elderly Advisory Board expressed it's desire to administer the elderly complexes rather than the Indian Housing staff.

Mr. Pressler, the Yankton Sioux Elderly Case Management Services would like to express our support for any proposal which, if adopted, would improve vastly the operation of a program of vital importance to efforts by tribes and tribal members to engage in

activities which benefit Indian elderly. We, therefore, strongly urge the congress to adopt measures that will permit the Bureau of Indian Affairs to provide funding or grant monies for programs other than direct services to clients as is the present case. We likewise strongly urge support for the existing federal programs serving the elderly on this reservation and nationwide, and at a funding level consistent with the cost of living fluctuations.

"Pursuant to treaties whereby Indian tribes exchanged vast land areas in return for the promise of federal support for Indians, the federal government has a trust obligation to assist tribes in their quest for relief of distress and conservation of health among Indian elderly."

I recount here in summary form the dark descriptions of the welfare system reported as late as 1928 as a reminder that contemporary society be ever mindful of, and responsive to, the needs of the elderly: "Old, crippled, almost helpless Indians are required to come to the agency office in all sorts of weather to get their supplies. On several reservations the survey team saw poorly clad, old people, with feet soaked by long walks through snow and slush, huddled in the agency office waiting for the arrival of the superintendent or other officer who could give them an order for rations to keep them from actual starvation."

Fortunately, the present situation of our elderly is better, yet, Mr. Pressler, and distinguished members of the Senate Aging Committee, the elderly on the Yankton Sioux Reservation are not persuaded that their needs and concerns are adequately met. The Yankton Sioux elderly stand collectively opposed to any budget reduction in Title VI funding, to any reductions in Indian Health Centers, hospitals, to Social Security changes, to the Food Stamp programs, and Medicare/Medicaid, and urge the creation of an office on Aging within the Bureau of Indian Affairs. Lastly, to any overall reductions in

programs designed to provide for their dignity, security, and welfare guaranteed them.

The elderly on the Yankton Sioux Reservation understand that to create a comprehensive elderly Indian program on the Yankton Sioux Reservation invokes such questions as:

1. Necessity of such a program.
2. Type and range of such a program.
3. What agency should administer the program.

Again, the consensus of the elderly is that the Yankton Sioux Tribe is in a better position to hear and be responsive to elderly needs, and that moreover the responsibility rests with tribal government. However, since the Yankton Sioux Indian Reservation area is disfavorably characterized with 1.) extreme poverty, 2.) high unemployment, 3.) poor health, and 4.) low educational attainment, then it becomes the duty of the federal government to assist this tribe in it's quest to provide a safe and sanitary environment for the elderly by virtue of treaty commitments.

In conclusion, we strongly impress upon the committee the urgency of remedying the distress of the elderly on the Yankton Sioux Reservation and nationwide for the unmeasurable benefits proposed and supported here will uplift the spirit in an area that has been utterly deprived.

Item 16

TESTIMONY BY

COMMISSIONER ON AGING

CAROL FRASER FISK

U.S. ADMINISTRATION ON AGING

Senator Pressler, I want to thank you for this opportunity to offer testimony today on benefits and services to Indian elders under the Older Americans Act. The Administration on Aging is deeply committed to assuring that all American Indian elders are afforded the opportunity to participate fully in Older Americans Act programs. In my statement, I wish to present an overview of services to American Indian elders under the Act and to describe the progress made by the Administration on Aging in implementing the 1987 Amendments to the Older Americans Act (PL 100-175) as they affect Indian elders.

Title III of the Older Americans Act provides for grants to State and community programs on aging. Title III is designed to build comprehensive systems of services for older persons in communities throughout the Nation. The goal of this effort is to provide opportunities for older persons to live independent, meaningful and dignified lives in their own homes and communities as long as possible. Resources are made available to assist communities to provide supportive services such as information and referral, transportation, and legal assistance, and nutrition services including both congregate and home-delivered meals. Title III programs are administered by State Agencies on Aging and the area agencies on aging that the State agencies designate. There are currently 662 area agencies on aging. State agencies have designated nine American Indian tribal organizations as area agencies on aging.

In FY 1987 there were 39,506 older Indians (age 60 or over) who received supportive services under Title III, Part B, of the Older Americans Act. A total of 29,458 older Indians received congregate meals under Title III, Part C-1, while 7,997 older Indians received home-delivered meals under Title III, Part C-2.

In 1978 Congress amended the Older Americans Act to enact Title VI, a grant program specifically for American Indian tribal organizations. The 1978 amendments set forth the relationship between Title III and Title VI. Services provided under Title VI are to be comparable to those provided under Title III.

The 1987 amendments to the Act made significant administrative and programmatic changes in Title VI. Previously the Act had prohibited an Indian elder who was eligible to receive services under Title VI from receiving services under Title III. This prohibition was deleted in 1987. The 1987 Amendments also revised Title VI to provide for two parts, Part A for American Indian and Alaskan Native elders, and a new Part B for Native Hawaiian elders. Grants may be made under Part B only if the total appropriation for Title VI (Parts A and B combined) exceeds $7,500,000.

In the current fiscal year (FY 1988), the Administration on Aging has awarded $7,181,000 of Title VI funds to 136 tribal organizations. All programs provide meals for Indian elders. Supportive services such as information and referral, transportation, legal, ombudsman, and in-home health vary from Tribe to Tribe according to the need of the elders. On reservations receiving both Title III and Title VI funds, the services are coordinated. Regional Office staff of the Administration on Aging carry out a range of training, technical assistance and other management functions designed to assure high quality programming by State agencies and tribal organizations.

Program performance data for FY 1986, the latest year for which we have complete data, indicate that the Title VI program continues to maintain a very high participation rate. Of the eligible population of 35,015 in FY 1986, about 90% participated in nutrition services, and 60% received one or more supportive services. The two supportive services most frequently used are transportation and information and referral. Let me note in this connection that the Title VI program attracts a large number of volunteers (approximately 60% of staff) who assist in providing services to Indian elders.

In addition to activities under Titles III and VI of the Act, tribal organizations are also encouraged to submit applications for grants under Title IV, Training, Research, and Discretionary Projects and Programs. Several sections of the FY 1988 Title IV announcement were of particular relevance to Tribes--Research on Native American Aging, Minority Management Traineeship Program, Training for Indian Tribe Directors of Title VI Programs, and Prevention and Treatment of Alcoholism among older Indians.

Beyond the different types of grants authorized by the Older Americans Act which benefit Indian elders, the Act, by the 1987 Amendments, also calls for the establishment of an Office for American Indian, Alaskan Native and Native Hawaiian Programs within the Administration on Aging. I have initiated a series of specific steps to establish the Office, which is to be headed by an Associate Commissioner on American Indian, Alaskan Native and Native Hawaiian Aging, to be appointed by the Commissioner.

To assist me in the process of setting up the new Office and implementing other statutory provisions affecting Indian elders, Dr. J. T. Garrett from the Indian Health Service has been temporarily assigned to serve as my Special Advisor for Native American Elders. Dr. Garrett is a commissioned officer in the Public Health Service and is a member of the Eastern Band of Cherokees. I have also assigned selected AoA staff to assist Dr. Garrett in carrying out a variety of responsibilities relative to the 1987 Amendments on Native American elders. The necessary materials to organize the new Office have been submitted within the Department.
In addition to the establishment of the Office for American Indian, Alaskan Native and Native Hawaiian Programs and the appointment of an Associate Commissioner, the 1987 Amendments include other significant requirements which affect the wellbeing of Indian elders. These requirements include: the establishment of a permanent interagency task force on older Indians, the preparation of a special report on services for Indians elders, and a continuing assessment of the services available to older Indians.

The task force is to consist of representatives of departments and agencies of the Federal Government with an interest in

older Indians and their welfare. Chaired by the Associate Commissioner on American Indian, Alaskan Native, and Native Hawaiian Aging, the task force is charged with making recommendations to facilitate the coordination and improvement of services to Indian elders. Plans for implementation of the task force have been prepared pending approval of the proposed Office for American Indian, Alaskan Native and Native Hawaiian Programs.

The 1987 Amendments also call for the Commissioner on Aging to enter into a contract with a public agency or nonprofit private organization to conduct a thorough study of the availability and quality of services under the Act. Information developed is to include an analysis of how many Indians are participating in Title III and Title VI programs, a description of how these grants are awarded to tribes, and an analysis of how well the Administration on Aging is assuring that services under Title VI are comparable to those under Title III. This report is to be submitted to Congress by December 31, 1988. Arrangements for collecting data for the study have been implemented through an Interagency Agreement with the Indian Health Service.

Finally, the Amendments also require the Associate Commissioner on American Indian, Alaskan Native, and Native Hawaiian Aging to undertake an evaluation of the adequacy of outreach to Indian elders under Title III and Title VI. Information on these services will be included in the annual report required by section 207(a) of the Older Americans Act. The Interagency Agreement with the Indian Health Service will also provide for studies on services to Indian elders which will report on the status of service delivery, outreach, and coordination between III and VI.

The Administration on Aging is committed to strengthening the development of comprehensive community based systems to more effectively serve Indian elders. I am pleased that the Administration on Aging is in a position to be even more responsive to the critical issues and needs of our special and unique population of American Indian elders. Thank you for allowing me the opportunity to provide written testimony on behalf of the AoA in its mission to better coordinate and serve our American Indian elders.

Item 17

NATIONAL AMERICAN INDIAN HOUSING COUNCIL
321 D Street, N.E. 2nd Floor
Washington, D.C. 20002

George Nolen
Chairman
(908) 635-6060

Virginia E. Spencer
Executive Director
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Testimony of Virginia E. Spencer

Before The

Senate Special Committee on Aging

Mr. Chairman and members of the Senate Special Committee on Aging, my name is Virginia Spencer and I am Executive Director of the National American Indian Housing Council. I am pleased to provide you with testimony on housing and the American Indian elderly. I also want to thank you, Senator Pressler, and other members of this Committee, for your support and commitment to Indian housing expressed by your passing the "Indian Housing Act of 1988," Public Law 100-358.

American Indian and Alaska Native Housing

The 1980 Census counted 1.4 million American Indians, Eskimos, and Aleuts in the United States, and may well have missed many more. About half of the Indian population lives either on reservations or in rural areas near those reservations. About two thirds of the 1980 rural Indian population (449,781) lived on reservations, tribal trust lands, historic Indian areas in Oklahoma or Alaska Native Villages. Assuming that Indian population has increased at the 1970-80 rate, there are now over one million rural and reservation Indians. A tragically high proportion face almost unsurmountable housing problems.

Almost one quarter of all American Indians live in housing that either lacks basic plumbing facilities or is overcrowded, four times the proportion for the country as a whole. One reason for this is poverty: Indians are more than twice as likely to be poor as other Americans. In addition to poor housing, a safe water supply is a major problem on many reservations. While the incidence of unsafe water for the nation as a whole is about 3%, the average for Indians on reservations is 20-25%.

According to the 1987 Bureau of Indian Affairs (BIA) survey of reservation housing, in 1987, only half (49.9%) of the 186,000 households on Indian reservations lived in standard housing. Almost one household in ten (8.9%) lived in housing that was so bad it needed to be replaced. One household in five (21.5%) lived in units needing rehabilitation. Perhaps worst of all, more than one household in four (28.6%) had no housing of their own, and either lived doubled up with relatives or friends, or in cars, tents, or temporary shelters. In all, BIA found a need for 93,000 new or substantially rehabilitated homes on Indian reservations. In 1970, the comparable figure was 63,000.

Experience has demonstrated that neither the regular programs of HUD nor the somewhat more flexible, rural-oriented programs of the Farmers Home Administration (FmHA) have proved usable in Indian country. Special housing programs are needed to meet Indian housing needs. Yet a series of programs which have worked effectively in providing decent housing on Indian reservations has suffered deep cuts in recent years.

The newly enacted Indian Housing Act of 1988 now provides a solid basis for moving ahead with an expanded program to meet Indian housing needs. To do this, the federal government will have to provide the needed funding and programs, in consultation with Indians and working through tribal agencies on reservations. This will require both addressing low income housing needs, by providing at least 6,000 additional units each year, and developing new ways of serving families and the elderly who could pay for housing if they could obtain financing.

American Indian Elderly

The proportion of elderly among the American Indian population has grown faster than in any other group. Between 1970 and 1980 their numbers increased by 65%, a rate twice that of the white or black elderly. (National data, American Association of Retired Persons (AARP), 1986). Older Indians comprise only 8% of the total Indian population, however, the number of elder Indians is expected to reach more than 200,000 by the year 1990. Life expectancy at birth for American Indians and Alaska Natives has increased from 51.0 years in 1939 - 1941 to 71.1 years in 1979 - 1981. However, it is still 3.3 years less than the 1980 figure of 74.4 for the U.S. white population. (National data, Indian Health Service Chart Series Book, 1987).

The major health problems of American Indian elders are tuberculosis, diabetes, liver and kidney disease, high blood pressure, pneumonia and malnutrition. (AARP).

Indians have staggering health problems. They have one of the highest infant mortality and lowest life expectancy rates of any group in the United States. What is most disturbing is the Indian death rate from curable diseases, such as tuberculosis and influenza, which approaches four times the national average. Many of their physical illnesses are directly related to malnutrition and substandard housing.

Substandard housing conditions cause serious health problems for Indian elders. Crowded living conditions, insufficient quantities of safe water and the lack of sanitation facilities help spread disease.*

Information provided to the National American Indian Housing Council from the Sault Ste. Marie Tribe of Chippewas exemplifies Indian elderly housing problems:

> Most of the typical housing problems that face our elderly today are associated with sub-standard housing which creates hazardous living conditions.
>
> The most common of these problems are a lack of insulation and air infiltration. Single pane windows with little or no caulking is another factor in the sub-standard homes. This causes heat loss in the winter months, creating higher heating bills and over-labored furnace systems. In some cases, the over-labored furnaces produce toxic fumes that has hospitalized our elders.
>
> Deteriorated roofing is another problem that occurs frequently. When this problem occurs, it affects many items. For instance, rain can destroy the "R" factor of the insulation and rot the rafters.
>
> Foundations, if any, in most of the elderly homes are usually settling and breaking apart, which throws off the delicate precision of a home. This causes almost everything to be off square and causes spacing around the windows and doorways.
>
> One of our major concerns are the problems encountered by our handicapped elders. Most of the homes of this group are not equipped with the devices necessary for them to lead a safe and sanitary life.
>
> The astronomical prices of handicapped equipment does not allow the elderly handicapped persons who live on a fixed income to purchase the equipment they need to live under safe and sanitary conditions.

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* Pevar, Stephan. The Rights of Indians and Tribes. Published for the American Civl Liberties Union by Bantum Books, New York, 1983.

Many of our elders haul their own water because of contaminants in their wells, or because their wells have gone dray. This causes many health related problems connected with not having sanitary facilities within the home.*

According to the National Indian Council on Aging (NICOA), more and more Indian leaders are falling below the poverty line. If this trend continues, the quality of life will continue to deteriorate for them. Please consider what effects the following program cuts have on Indian elders:

- funds for HUD Indian housing programs have been reduced by 66% since 1981;

- HUD will not permit the building of a Mutual Help Home for an elder 62 years of age or over, yet 65% of the HUD Indian Housing Program are Mutual Help units;

- the Indian Health Service has eliminated from its budget many services most needed by our elders (eg., eyeglasses, hearing aids, dentures, prosthetics, etc.);

- IHS has no focus on gerontology or geriatric care in its service delivery system;

- the CHR programs have been continually targeted for elimination from the IHS budget;

- BIA has not focused on the needs of elders; in fact, they do not even know how many elders are in need of services;

- unemployment has taken a big jump on reservations where energy companies were the main source of jobs -- this means that more and more of those who would normally help to support their elders are no longer able to do so;

- resources under Title III, V and VI of the Older Americans Act, supposedly targeted toward those in the greatest of economic and social needs are even less available to Indian elders today than they were four years ago; and

- there seems to be a growing disregard in our Congress and in federal agency policies for treaty obligations to Indian tribes and for services designed to help the truly needy.

In addition, under the HUD program, "elderly" is defined as 62 years and over, while under the Bureau of Indian Affairs Housing Improvement Program, the BIA recognizes Indians 55 years and over as eligible for "elderly" assistance. The National American Indian Housing Council recommends a lowering of age to 55 for Indian elderly for HUD eligibility (see Appendix 1).

As you can see from the above comments on typical conditions and current program cut-backs, American Indian elders are finding themselves in increasingly stressful conditions. Housing for many elders is totally inadequate. In 1981, the Native American Rights Fund held citizen hearings on Indian housing in several areas of the United States. At that time a witness from the Winnebago Tribe in Wisconsin testified that in the outlying areas of his reservation several families continued to live as they had in the 1950's in wigwams, without, of course, plumbing and electricity. Most of them are elders who are adamant about continuing to live on the same land they grew up on. Money is not available so they construct traditional structures. It is a hard life, but to these people it is harder to live elsewhere.

A witness from San Carlos Apache presented slides of housing conditions of the elderly on that reservation. Many of the elders live in 10' x 10' shanties expanded with an open-air arbor used during the warmer weather for cooking and sleeping. One slide showed the "house" of an old woman which consisted of a tent pitched under a permanent roof structure supported by poles. For her this was home, summer and winter.

* Photographs can be provided on request.

Obviously, housing and housing assistance to Indian elders must be improved and made a priority, but enormous sensitivity must be used in "improving things." Safe and adequate drinking water supplies and sanitary sewage disposal must be provided to all Indian communities. Housing assistance programs must meet the needs of the elderly - on their own homelands. Due to extreme poverty, housing improvement and new construction grants should be utilized to develop warm and dry, affordable homes. A continuing Federal commitment must be made as no other means of financing homes can be made on trust lands. While housing development programs are expensive, what is the cost to Indian tribes and American society when our elders suffer ill health, poverty and bad housing?

The National American Indian Housing Council urges this Committee, and all members of Congress, to continue to provide support for housing assistance and safe, sanitary water and sewer facilities to all American Indian and Alaska Native communities. For our elders, please help us provide the support necessary to make their old age, comfortable to live in beauty and peace.

Appendix I

National American Indian Housing Council

Resolution 88-22

LOWER ELDERLY QUALIFICATION TO 55

WHEREAS, the National American Indian Housing Council (NAIHC) is representative of and advocates for national, regional and tribal housing concerns and issues; and

WHEREAS, the NAIHC is a national organization comprised of Indian Housing Authorities in HUD Regions; and

WHEREAS, the life expectancy of the American Indian is less than that of the overall population of the United States; and

WHEREAS, the Bureau of Indian Affairs recognizes this fact and sets the age for elderly at age 55 for the Housing Improvement Program (HIP);

NOW, THEREFORE, BE IT RESOLVED, that HUD lower the definition of elderly from age 62 to age 55 for the HUD Indian Housing Programs.

This resolution was passed unanimously at NAIHC's Annual Convention held in Rapid City, South Dakota, June, 1988.

Item 18

TESTIMONY OF COMMISSIONER TONY GALLEGOS
OF THE U.S. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION
SUBMITTED TO THE SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE
PINE RIDGE, SOUTH DAKOTA
JULY 21, 1988

Thank you Senator Pressler for affording me the opportunity to present written testimony on the problems facing American Indians in today's society.

I have always had a keen interest in the issues affecting American Indians. One reason for my interest is the fact that my father was born and raised at the Taos Pueblo in the State of New Mexico. The other reason is my involvement, as a Commissioner at the Equal Employment Opportunity Commission, with one of the most effective programs founded by the federal government -- the Tribal Employment Rights Offices Program. The TERO program has been successful, not because of what any federal agency has done, but because of the determination and effort of each TERO to be economically self-sufficient.

Since my appointment to the Commission in 1982, I have been fortunate to have had the opportunity to see the TERO program develop from a program destined for extinction to a program that is successfully applying the concept of Indian self-determination to economic development.

ADEA AND TERO STATISTICS

In your letter of invitation, you requested specific information regarding American Indians and enforcement of the ADEA. I would like to address these areas.

EEOC does not request or determine the race of persons filing ADEA charges. As a result, I cannot provide you with the number of ADEA charges filed by American Indians. The TERO program deals with Title VII issues. As you are aware, the ADEA is a separate law and TEROs do not fall under it. As a result, an Indian who wishes to file an ADEA charge is referred to the appropriate EEOC field office.

As a result of not being able to specifically identify American Indians filing age claims, we are unable to provide information as to whether any claims by them passed the ADEA statute of limitations.

I believe awareness of elderly American Indians of TEROs and EEOC has risen considerably since I have been at the Commission. As I stated earlier, the program faced extinction. It has not just survived, it has prospered. By prospered, I mean provided relief for Indians in terms of dollars, jobs and hope for the future. Word gets around on reservations about successes. TERO is successful. As a TERO director achieves more benefits, people who live on or near the reservation discuss it and awareness increases.

The cultural barriers which may lead to reluctance to file discrimination charges are no different for elderly Indians than for other Indians. Ambivalence toward the federal government, concern for preserving autonomy in internal affairs and tribal loyalties may be barriers. However, over the years we have seen these barriers slip. TEROs and tribal councils look to EEOC as a model for federal/tribal relationships. TEROs are EEOC agents on the reservation. Thus, the contact is not with the federal government, but with a tribal member. Confidence in the services provided is much higher and as a result, barriers are giving way.

TRIBAL EMPLOYMENT RIGHTS OFFICES

The vast majority of employment discrimination problems facing elderly American Indians today are not based upon age, but upon race. All American Indians, not just the elderly, represent "The Forgotten Population." I am not contending that age discrimination does not occur in the Indian population; however it is deeply overshadowed by the primary reason American Indians are discriminated against--and that is because of their race. The Tribal Employment Rights Offices (TEROs) were created to help end discrimination against American Indians in the work place.

A Tribal Employment Rights Office (TERO) is the name given to a unit within the tribal government structure whose purpose is to encourage and facilitate the use of Indian employment in businesses and industries located within the geographical boundaries of the reservation. To achieve these ends, the TERO seeks to identify, eliminate and remedy illegal employment discrimination.

TEROs also direct seminars and conferences which serve as educational processes in making tribal members more aware of their special preference rights and of their federal employment rights.

EEOC's role in the TERO program is to provide funding and training to Indian tribes and to assist in the continued development of the TEROs' ability to identify, remedy and eliminate unlawful employment discrimination occurring on or near the reservations.

EEOC first became involved with TERO in 1976, when it let a contract to an Indian-owned consulting firm to establish 15 Tribal Employment Rights Offices. The tribes were selected for participation by the contractor and EEOC on the basis of interest, the potential for a successful model program and the tribes' willingness to commit at least one staff person to the program.

Out of respect for the diversity of each participating tribe, the contract allowed the tribes full license to work toward the enforcement provisions of Title VII according to the needs of and political climate surrounding each reservation.

At the end of the contract period, it was determined the project was successful and 15 TEROs were established. Interest in the program continued to grow and EEOC entered into a second contract with the firm to establish 10 additional TEROs. This project also was very successful. There were now 25 TEROs established, which completed the first step in achieving equal employment rights for Indians on reservations.

The next step was to solidify an EEOC/TERO relationship whereby EEOC would fund TEROs under a demonstration contract to assist in promoting and protecting the employment rights of Indians working for private employers on reservations.

Tribal governments have the inherent sovereign power to regulate commercial dealings by all entities within their jurisdiction, which gives them the authority to require employers on the reservations to give preference to Indians in employment and business opportunities. The tribes can:

. set the minimum number of Indians each employer must hire for each craft or job classification,

. review the employer's job qualifications to make sure there are no qualifications that are irrelevant to good performance,

. set up a hiring hall system to refer applicants to employers,

. set up a training program that requires employers to hire a certain number of partially trained Indians and continue to train them on the job.

TEROs operating under contracts with EEOC enforce the above tribal ordinances, serve as referral and placement links between employers and residents of the reservations, negotiate Indian preference agreements and take and process complaints of employment discrimination.

Complaints of employment discrimination are processed by TEROs under tribal ordinances and under Title VII of the Civil Rights Act. For processing a charge under Title VII, EEOC developed specific procedures for TEROs to follow which allow the TERO 30 days to negotiate a settlement. If settlement is not reached, the TERO notifies EEOC that a settlement attempt was unsuccessful and EEOC will take control of the charge on the 31st day.

TEROs do a great deal of what we refer to as preventive maintenance. They use employment rights laws to compel employers to hire and promote Indians. Being a part of a sovereign government, they operate under statutory authority of those sovereigns. TEROs meet with new employers coming onto the reservations and explain the requirements of their tribal ordinances.

Once an Indian is hired, the TERO works with the employee and the employer to ensure retention. If a problem arises that can be solved, the employer is required to retain the employee while TERO makes the appropriate referrals to get help for the individual. In many instances it prevents the need for filing a charge.

Prior to 1983, it was generally recognized that one area where EEOC had not functioned as effectively as it should was in providing service to American Indians. In addition to that concern was the concern that many of the Commission's staff were not familiar with American Indian problems and issues. Since 1983, when the Commission approved funding for 20 TEROs, EEOC has made the effort each year to expand and improve the TERO program usually in the face of budgetary constraints. In fiscal year 1986, despite Gramm-Rudman budget cuts, the Commission not only increased the number of TEROs funded to 36 but also was able to avoid any reduction in TERO funding.

The TEROs were so effective that in FY 1987 the Commission funded 44, and in FY 1988 the number increased to 53. Congress earmarked just $20 million for state and local programs for 1988 as it had in previous years. Congress has proposed the same $20 million funding for FY 1989. Every year for the past seven years Congress has appropriated less than the President requested for EEOC's budget. Because Congress did not fund EEOC at the requested level, the Commission will not be able to increase the TERO contract amount for next year or fund any new TEROs.

In FY 1987, the 44 TEROs processed 382 complaints of employment discrimination--most of which were handled under tribal ordinances. Of these 382 complaints, the TEROs successfully settled 253. As a result of complaint settlements and placement of American Indians, the TEROs obtained over $20 million in benefits for 6,065 individuals. The monetary benefits obtained in 1987 were substantially more than in 1986 --a banner year when monetary benefits of over $15 million were obtained. That was twice as much as the total monetary awards collected in all the previous years of the TERO program.

In addition to their settlement efforts, the 44 TEROs negotiated 2,049 preference agreements with employers working on or near the reservations. They also conducted 6,183 on-site inspections of employer operations to ensure that employers were complying with current preference agreements. Further, the 44 TEROs prevented the need for filing charges of discrimination through preventative activities that affected over 53,000 individuals.

But it doesn't end there: TEROs were also responsible for referring over 15,000 Indians for jobs, recruiting 18,000 and placing 7,555 Indians with employers.

Numbers alone cannot tell us the whole story. They don't reveal all the effort and dedication that the TERO staff pour into their jobs, nor the difference they make in improving the quality of life for thousands of individuals. These numbers do tell us, however, that the TEROs are working hard and are very successful. At a funding rate of only $22,500 each, the TEROs more than pay for themselves and constitute one of the most effective programs funded by the federal government.

However, TEROs have on occasion been met with resistance from some employers and contractors. In my opinion, this employer reluctance to abide by the TERO ordinance is due largely to a lack of understanding of what Indian employment preference is all about and what the TERO program is all about.

The EEOC recently issued a policy statement clarifying the Indian preference provision of Title VII. I believe this policy statement strengthens and clarifies Section 703(i) of Title VII and will aid in prohibiting discrimination against American Indians. I am submitting a copy of this policy statement (Attachment A) for the hearing record.

SCHOLARSHIP ENDOWMENT

The American Indian population in the United States faces difficult problems and issues now and in the years ahead. In terms of the needs of this segment of our population, the two most important are education and gainful employment.

The Indian population is the poorest and most under served in the nation--America's first forgotten minority. Indian students have a dropout rate of 60 percent between kindergarten and high school and half of all Indian youth above the age of 14 have no formal education. These figures are especially alarming when viewed against the projection that three-fourths of the 16 million new jobs over the next two years will require skilled training beyond high school. Obviously literacy and education are essential ingredients for the progress of all people and the betterment of our communities. Literacy and education are the first chapters in the American dream and without them, we cannot hope to get to the next chapter--gainful employment. The role of the TEROs is to assist in this important goal. We are proud of their accomplishments and look forward to their continued success.

Throughout the history of the United States, American Indians have consistently contributed to the strengthening of this nation. In times of war, they have stepped forward to fight for the principles upon which this country was founded. And those principles are reflected in the goals of a college I want to mention--D-Q University, a predominantly American Indian college. The reason I am mentioning D-Q University is because D-Q was chosen to receive a $50,000 scholarship endowment as an extension of a 1983 settlement agreement of a job discrimination charge between the EEOC and General Motors. The original EEOC-GM agreement established a $16 million education assistance program for minorities and women resulting in endowments to 32 colleges and universities.

The award ceremony took place at D-Q University on June 28, 1988. Such an award for a university with a primarily American Indian student body will result in resources to educate and prepare our Indian youth for entry into the business world on an equal footing with the rest of society.

EEOC AND ITS ENFORCEMENT OF THE ADEA

The Equal Employment Opportunity Commission is proud of its record of vigorously enforcing the Age Discrimination in Employment Act. In 1979, the Commission was given enforcement authority for the ADEA. Since that time the number of age discrimination charges has increased at a greater rate than any other category. This new challenge came at a critical time for the agency. Foundering under an ever increasing work load, the Commission implemented major initiatives in policy and management to establish the credibility and predictability of the agency's law enforcement efforts in order to better fulfill our responsibilities under all four of the acts we enforce. The Commission decided that this task could only be accomplished through a strong litigation program and a policy of seeking full relief for victims of discrimination.

The Commission's major policy initiatives include:

. an enforcement policy which calls for every case of discrimination which fails conciliation to be presented to the Commission for litigation consideration;

. a remedies policy which calls for a full remedy to be sought in every case where discrimination is found;

. an investigative compliance policy to enable EEOC to deal more effectively with respondents who fail to cooperate with Commission investigations; and

. a method for charging parties to appeal to EEOC headquarters determinations by field offices that no cause has been found to believe discrimination has occurred.

A number of administrative and management tools have been employed by this Commission to support the agency's enforcement program. Among those tools are improved financial accountability, computerization, goal-oriented employee performance agreements, a streamlined organizational structure and implementation of a Commission-wide quality assurance program. In June 1987, EEOC for the first time in Commission history comprehensively trained virtually all (1,400) field investigators. This comprehensive training of investigators is now a continuing part of the Commission's staff development program. The training was recently given to new investigators and attorneys from the field as well as to headquarters personnel. This training program is another important element in the Commission's ongoing work to improve the quality, effectiveness and efficiency of its service to the public.

The Commission also has developed unique, personalized outreach programs designed to augment the deterrent effect of its enforcement through public education and assistance. In addition, the Commission provides charging parties with a full explanation of their rights at the time they contact us to file a charge.

Predictable, efficient law enforcement and insistence on full remedial relief have benefited victims of age discrimination. As Congress recognized in enacting the ADEA, those who suffer from age discrimination must have prompt vindication of their rights for any legal relief to be meaningful. Accordingly, this Commission has aggressively investigated and prosecuted claims of age discrimination on an individual, classwide and a systemic basis.

Statistics on the numbers of cases satisfactorily concluded, lawsuits initiated and monetary recoveries obtained clearly show this Commission's commitment to eradicating age discrimination and the public's growing trust in our processes, as well as our credibility as a law enforcement agency.

We are pleased to keep this Committee informed of the Commission's record of accomplishment and commitment to the purposes of the ADEA: to promote employment of older persons based on their ability rather than age; to prohibit arbitrary age discrimination in employment; to help employers and workers find ways of meeting problems arising from the impact of age on employment.

I remain personally and professionally committed to the success and well-being of the American Indian people. They truly are one of America's natural and best resources. Training and the opportunity for fair and gainful employment are essential. It follows that the goal of equal employment opportunity be available for everyone. I commend Senator Pressler for holding these hearings. I am pleased EEOC has been provided the opportunity to further enlighten the committee of this agency's commitment and progress in its mission of equal employment for all American Indians.

EEOC

NOTICE

(Automatically Cancelled in 180 Days)

NUMBER N-915-027

DATE 5/16/88

1. SUBJECT. Policy Statement on Indian Preference Under Title VII.

2. PURPOSE. This policy statement sets forth the Commission's interpretation of the meaning and scope of the Indian preference provision contained in Section 703(i) of Title VII of the Civil Rights Act of 1964, as amended.

3. EFFECTIVE DATE. May 16, 1988

4. EXPIRATION DATE. As an exception to EEOC Order 205.001, Appendix V, Attachment 4, § a(5), this Notice will remain in effect until rescinded or superseded.

5. ORIGINATOR. Title VII/EPA Division, Office of Legal Counsel.

6. INSTRUCTIONS. This notice supplements the discussion at Section 604.10(d) of EEOC Compliance Manual, Volume II, Section 604, Theories of Discrimination. The notice should be filed behind the appendices to that section.

7. SUBJECT MATTER.

Section 703(i) of Title VII of the Civil Rights Act of 1964, as amended, 42 U.S.C. § 2000e-2(i) (1982), provides an exception to Title VII's general nondiscrimination principles allowing certain employers under certain circumstances to exercise an employment preference in favor of American Indians. 1/ That section provides as follows:

> Nothing contained in this title shall apply to any business or enterprise on or near an Indian reservation with respect to any publicly announced employment practice of such business or enterprise under which a preferential treatment is given to any individual because he is an Indian living on or near a reservation.

The statutory language makes it clear that an employer seeking to avail itself of the Indian preference exception must meet three conditions: (1) the employer must be located on or near an Indian reservation, (2) the employer's preference for Indians must be publicly announced, and (3) the individual to whom preferential treatment is accorded must be an Indian living on or near a reservation. Neither Section 703(i) nor any other section of the Act, however, defines the terms "Indian reservation" or "near."

1/ This policy statement does not extend to charges/complaints brought under either the Age Discrimination in Employment Act of 1967, as amended (ADEA), 29 U.S.C. § 621 et seq. (1982), or the Equal Pay Act of 1963 (EPA), 29 U.S.C. § 206(d) (1982), since, unlike Title VII, neither of those statutes contains an Indian preference exception. Additionally, neither the ADEA nor the EPA provides a jurisdictional exemption for Indian tribes as does Section 701(b)(1) of Title VII.

Although the Commission has issued several decisions involving the jurisdictional exemption of Indian tribes under Section 701(b)(1) of Title VII, 2/ its one published decision involving the Indian preference exception under Section 703(i) of the Act turned solely on the question of whether the employer had satisfied the public announcement requirement of that section. See Commission Decision No. 74-26, CCH EEOC Decisions (1983) ¶ 6398. Thus, the Commission did not have occasion in that case to address the statutory requirement of being "on or near an Indian reservation."

Because the Commission has received various requests from employers, Indian tribes, and state fair employment practices agencies for its interpretation of the "on or near" phrase and the applicability of the Indian preference exception and because the issue is an increasingly important one on which the Commission has not previously issued guidance, the Commission now delineates its position with respect to the exception provided in Section 703(i) of the Act. Specifically, the Commission addresses: (1) the definition of "Indian reservation" for Title VII purposes, (2) the meaning of the term "near," (3) the scope of the term "employment practice," and (4) the issue of whether a preference based on tribal affiliation conflicts with the provisions of Title VII.

Indian Reservation

The need to define the term "Indian reservation" within the meaning of Section 703(i) of Title VII arises in connection with the circumstances that exist in the state of Oklahoma. As has been brought to the Commission's attention, Oklahoma is the home of a large number of Indian tribes and many areas of the state contain high Native American populations, yet there are no longer any Indian reservations as such in Oklahoma. 3/ Many employers in the state, however, are located in and around the sites of former reservations. Thus, the question presented is whether the Indian preference exception provided in Section 703(i) is available to such employers or whether applicability of that provision is dependent upon the present existence of an Indian reservation as the necessary base from which to measure whether the "on or near" requirement is met.

The issue is one of first impression. As noted above, Title VII does not define the term "Indian reservation." Nor is there any indication in the legislative history of the Act of the meaning intended by Congress in its use of that term in Section 703(i). Further, research has disclosed no court decision defining the term for Title VII purposes.

2/ See Commission Decision No. 80-14, CCH EEOC Decisions (1983) ¶ 6823, and Commission Decision Nos. 85-6 and 85-7, CCH Empl. Prac. Guide ¶¶ 6847 and 6848, respectively.

3/ Prior to statehood in 1907, the area comprising present-day Oklahoma was Indian Territory. For a detailed discussion of the history of that land, see F. Cohen, Handbook of Federal Indian Law 770-75 (1982 ed.). See also S. Pevar, The Rights of Indians and Tribes 231-33 (Bantam ed. 1983).

Before examining statutory use of the term outside the context of Title VII, we consider its ordinary meaning:

> The term "Indian reservation" originally had meant any land reserved from an Indian cession to the federal government regardless of the form of tenure. During the 1850's, the modern meaning of Indian reservation emerged, referring to land set aside under federal protection for the residence of Tribal Indians, regardless of origin. 4/

Although "Indian reservation" is the more commonly familiar term, the governing legal term for most jurisdictional purposes is "Indian country." 5/ The latter is defined at 18 U.S.C. § 1151 as follows:

> Except as otherwise provided in sections 1154 and 1156 of this title, the term "Indian country," as used in this chapter, means (a) all land within the limits of any Indian reservation under the jurisdiction of the United States government, notwithstanding the issuance of any patent, and, including rights-of-way running through the reservation, (b) all dependent Indian communities within the borders of the United States whether within the original or subsequently acquired territory thereof, and whether within or without the limits of a state, and (c) all Indian allotments, the Indian titles to which have not been extinguished, including rights-of-way running through the same.

The definition in Section 1151 is controlling with respect to the applicability of federal criminal law in Indian country. While this definition relates specifically to determinations of federal criminal jurisdiction, the Supreme Court has noted that it is also applicable to questions of federal civil jurisdiction. 6/ However, although Indian reservations are included in the statutory definition of Indian country, the term "Indian reservation" is not separately defined. 7/

4/ Cohen, supra note 3, at 34.

5/ Id. at 27.

6/ DeCocteau v. District County Court, 420 U.S. 425 (1975). "While § 1151 is concerned, on its face, only with criminal jurisdiction, the Court has recognized that it generally applies as well to questions of civil jurisdiction." Id. at 427 n.2 (citations omitted).

7/ In determining whether a particular tract of land constitutes a reservation within the meaning of § 1151(a), courts have examined the history of the land in light of acts of Congress, rulings by the Department of the Interior, and prior judicial decisions bearing on its status. See, e.g., United States v. John, 437 U.S. 634 (1978); Cheyenne-Arapaho Tribes v. State of Oklahoma, 618 F.2d 665 (1980); and Langley v. Ryder, 602 F. Supp. 335 (W.D. La. 1985).

Similarly, the terms "Indian reservation" or "reservation" appear but are undefined in numerous other federal statutes. 8/ A review of Title 25 of the U. S. Code, which pertains specifically to Indians, has disclosed only three instances in which "reservation" is defined, although the term is used repeatedly throughout that title. 9/ Of these three definitions, one relates specifically to an Indian tribe in Connecticut. 10/ A second definition, which is of general application, is found in the Indian Child Welfare Act of 1978, 25 U.S.C. § 1901 et seq. Incorporating and expanding upon the definition of Indian country, that Act provides as follows:

> "[R]eservation" means Indian country as defined in section 1151 of title 18 and any lands, not covered under such section, title to which is either held by the United States in trust for the benefit of any Indian tribe or individual or held by any Indian tribe or individual subject to a restriction by the United States against alienation.

25 U.S.C. § 1903(10).

The third definition appears in the Indian Financing Act of 1974, 25 U.S.C. § 1451 et seq., which provides Indian tribes and individuals capital in the form of loans and grants to promote economic development. That definition specifically includes former Indian reservations in Oklahoma. As defined therein:

> "Reservation" includes Indian reservations, public domain Indian allotments, former Indian reservations in Oklahoma, and land held by incorporated Native groups, regional corporations, and village corporations under the provisions of the Alaska Native Claims Settlement Act [43 U.S.C. 1601 et seq.].

25 U.S.C. § 1452(d).

8/ See, e.g., 16 U.S.C. §§ 796(2), 797(e); 25 U.S.C. §§ 33, 46, 155, 175, 176, 196, 200, 211, 231-233, 253, 262, 264, 279, 280, 283, 286, 291, 292, 304, 307, 309, 311, 312, 318a-321, 331, 333, 334, 336, 337, 339, 340, 342, 344, 348, 350-352, 380, 381, 393, 396a, 397-399, 400a, 402a, 407, 415, 461, 463, 463e, 465, 467, 468, 476-479, 488, 501, 631, 1083, 1311, 1466, 1495, 1521; 43 U.S.C. §§ 149, 150, 851, 856, 868, 1195-1196.

9/ See citations to 25 U.S.C. supra note 8.

10/ See 25 U.S.C. § 1752 (Supp. III 1985).

While no statutory definition discovered other than that in the Indian Financing Act explicitly recognizes former Indian reservations in Oklahoma, they are included in the definition of "reservation" contained in various regulations promulgated by the Bureau of Indian Affairs (BIA) of the Department of the Interior. For example, in the regulations governing BIA's financial assistance and social services program, 25 C.F.R. § 20.1 et seq. (1987), the following definition is provided:

> "Reservation" means any federally recognized Indian tribe's reservation, Pueblo, or Colony, including former reservations in Oklahoma, Alaska Native regions established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688), and Indian allotments.

25 C.F.R. § 20.1(v) (1987). 11/

Against this background, the Commission must determine the meaning of the term "Indian reservation" under Section 703(i) of Title VII. In so doing, the Commission is mindful that Title VII is remedial social legislation and is, therefore, entitled to liberal construction in order to effectuate the purpose of the Act. 12/ The purpose for the inclusion of Section 703(i) is explained in the legislative history:

11/ The cited regulations were issued under 25 U.S.C. § 13, which authorizes BIA to expend money appropriated by Congress for the benefit, care, and assistance of Indians. For other instances in which BIA regulations define "reservation" as including former Indian reservations in Oklahoma, see 25 C.F.R. §§ 101.1(k) (loans to Indians from revolving loan fund), 103.1(h) (loan guaranty, insurance, and interest subsidy), 151.2(f) (land acquisitions), 273.2(o) (education contracts under Johnson O'Malley Act), and 286.1(j) (Indian business development program).

A similar definition is provided in regulations of the Department of the Interior (implementing Section 7(b) of the Indian Self-Determination and Education Assistance Act, 25 U.S.C. § 450e(b)), at 48 C.F.R. § 1404.7001 (1987). That section provides:

> "Indian reservation" includes Indian reservations, public domain Indian allotments, former Indian reservations in Oklahoma, and land held by incorporated Native groups, regional corporations, and village corporations under the provisions of the Alaska Native Claims Settlement Act (85 Stat. 688; 43 U.S.C. 1601 et seq.).

12/ See EEOC v. First Catholic Slovak Ladies Association, 694 F.2d 1068, 1070, 30 EPD ¶ 33,175 (6th Cir.), cert. denied, 464 U.S. 819, 32 EPD ¶ 33,829 (1983); and Zimmerman v. North American Signal Company, 704 F.2d 347, 352, 31 EPD ¶ 33,486 (7th Cir. 1983).

> A new subsection 703(i) has been added permitting enterprises on or near Indian reservations to follow preferential hiring practices toward Indians. This exemption is consistent with the Federal government's policy of encouraging Indian employment and with the special legal position of Indians. 13/

In the Commission's view, the Congressional purpose of encouraging the voluntary extension of employment opportunities to Indians would be unduly hampered by narrowly defining the term "Indian reservation" within the meaning of Section 703(i) to exclude former Indian reservations in Oklahoma. Such a definition would effectively preclude the applicability of Title VII's Indian preference provision to employers in a state which was originally Indian Territory and whose present population includes a high percentage of Native Americans, a result which appears contrary to the intent of Section 703(i). Additionally, the Commission takes note that a narrow definition of that term would similarly render the preference inapplicable in the state of Alaska. 14/

In light of these considerations, the Commission believes that the purpose of Section 703(i) would be furthered by defining "Indian reservation" in a manner that accords special recognition to the circumstances that exist in both Oklahoma and Alaska. Therefore, guided by the definitions of "reservation" provided in the Indian Financing Act of 1974 and in regulations issued by the Bureau of Indian Affairs, 15/ it is the Commission's position that the terms "Indian reservation " and "reservation" in Section 703(i) of Title VII include former Indian reservations in Oklahoma and land held by incorporated Native groups, regional corporations, and village corporations in Alaska under the provisions of the Alaska Native Claims Settlement Act.

Should a dispute arise regarding whether a particular tract of land falls within this definition, the Commission will present the question to the Bureau of Indian Affairs and will make its determination after consideration of the conclusion reached by that agency.

On or Near an Indian Reservation

Section 703(i) of Title VII uses the phrase "on or near an Indian reservation" in identifying the businesses or enterprises that may lawfully exercise the Indian preference exception provided in that section. The individual Indians to whom preferential treatment may be extended are similarly identified as those living "on or near a reservation." With respect to this phrase, the issue presented in determining whether the statutory criterion is met regards the meaning of the word "near," which is undefined in the Act.

13/ 110 Cong. Rec. 12723 (1964) (statement of Senator Humphrey).

14/ For a discussion of native land rights in Alaska, see Cohen, supra note 3, at 739-48.

15/ See supra note 11.

The sole Title VII case deciding the applicability of the Indian preference contained in Section 703(i) is Livingston v. Ewing, 601 F.2d 1110, 20 EPD ¶ 30,002 (10th Cir.), cert. denied, 444 U.S. 870, 20 EPD ¶ 30,266 (1979). In that case, the non-Indian plaintiffs challenged the policy of the Museum of New Mexico in Santa Fe of permitting only Indians to sell their handmade jewelry and crafts on the grounds of the Museum. Holding that the Museum's policy came within the Section 703(i) exception, even though the Museum was not the direct employer of the Indians, the court found that the "on or near" requirement was satisfied by facts showing that the Museum was located eight miles from an Indian reservation and within a "short distance" of other reservations, including the ones from which the Indians came. 601 F.2d at 1115.

However, because the court's holding in Livingston v. Ewing is fact-specific, the decision in that case does not provide a definition of the word "near" for Title VII purposes. Nor is general guidance on the meaning of that term found outside of Title VII in the Supreme Court's decision in Morton v. Ruiz, 415 U.S. 199 (1974). Although the Court there held that, in appropriating funds for the Bureau of Indian Affairs' general assistance program, Congress did not intend to limit eligibility for benefits under the program to Indians living "on" a reservation, to the exclusion of those living "near" one, the Court did not decide the breadth of the term "near." Rather, the Court held that it covered the Indian plaintiffs, who lived in an Indian community fifteen miles from their reservation.

Although applicable judicial precedent defining "near" is lacking, a definition of that term is found in regulations issued by the Office of Federal Contract Compliance Programs (OFCCP) of the Department of Labor. 41 C.F.R. § 60-1.1 et seq. (1987). The regulations, which apply to federal contractors, define "near" with reference to an Indian preference provision similar to that contained in Section 703(i) of Title VII. The regulations provide in pertinent part:

> Work on or near Indian reservations. It shall not be a violation of the equal opportunity clause for a construction or nonconstruction contractor to extend a publicly announced preference in employment to Indians living on or near an Indian reservation in connection with employment opportunities on or near an Indian reservation. The use of the word "near" would include all that area where a person seeking employment could reasonably be expected to commute to and from in the course of a work day.

41 C.F.R. § 60-1.5(a)(6) (1987) (emphasis added). 16/

16/ The Commission notes that the term "near" is similarly defined in Department of the Interior regulations implementing the Indian preference provision of the Indian Self-Determination and Education Assistance Act, 25 U.S.C. § 450e(b). At 48 C.F.R. § 1404.7001 (1987), these regulations provide:

> "On or near an Indian reservation" means on a reservation or the distance within that area surrounding an Indian reservation(s) that a person seeking employment could reasonably be expected to commute to and from in the course of a work day.

Upon considering the intent of Section 703(i), the Commission is persuaded that the definition of "near" in the OFCCP regulations cited above is consistent with and furthers the purpose of the Title VII provision. As noted, this definition appears in the specific context of an Indian preference provision that parallels that in Title VII. Unlike a definition that establishes the outer reach of that term by specifying a fixed distance applicable in all cases, a definition based on what may be considered reasonable commuting distance provides the flexibility necessary to take differing geographic and economic circumstances into account. Thus, since proximity to employment sources varies from one reservation to another and one part of the country to another, such a definition avoids potential inequities and promotes a fair application of the statutory exception.

For these reasons, the Commission adopts the definition of "near" provided in the OFCCP regulations set forth above as the definition of that term under Section 703(i) of Title VII. Applying this definition, determinations of whether the "on or near" criterion is met shall be made on a case-by-case basis.

Employment Practice

To what extent may preferential treatment be accorded Indians under Section 703(i)? That section provides an Indian preference exception with respect to "any publicly announced employment practice." The legislative history, discussed above, indicates that this exception permits covered employers to follow preferential hiring practices toward Indians. 17/ The question before the Commission is whether the term "employment practice" in Section 703(i) thus refers solely to initial hiring decisions.

In Morton v. Mancari, 417 U.S. 535, 7 EPD ¶ 9431 (1974), the Supreme Court upheld an employment preference for Indians in the Bureau of Indian Affairs (BIA) under Section 12 of the Indian Reorganization Act of 1934, 25 U.S.C. § 472. The Court held that the preference provided in the 1934 Act was not repealed by implication by the 1972 amendments to Title VII, which extended Title VII's discrimination prohibitions to federal sector employment. The Court further held that the preference did not constitute invidious racial discrimination in violation of the Due Process Clause of the Fifth Amendment. The statute at issue in Mancari provides a preference with respect to "appointment to vacancies." Although the preference previously had been accorded only at the initial hiring stage, under BIA policy as revised in 1972 it was extended to filling vacancies by original appointment, reinstatement, and promotions. 417 U.S. at 538 n.3. Because the question of whether the 1934 Act authorized a preference in other than initial hiring was not before the Court in Mancari, the Court noted that it expressed no opinion on that issue. Id. at 539 n.5. However, the Court cited two lower court decisions in which the phrase "appointment to vacancies" in Section 12 of the 1934 Act was specifically construed, Freeman v. Morton and Mescalero Apache Tribe v. Hickel.

In Freeman v. Morton, 499 F.2d 494 (D.C. Cir. 1974), the court held that the BIA preference applies to filling vacancies through initial hiring, promotion, lateral transfer, and reassignment. In Mescalero Apache Tribe v. Hickel,

17/ See supra note 13 and accompanying text.

432 F.2d 956 (10th Cir. 1970), cert. denied, 401 U.S. 981 (1971), the court concluded that the preference was not applicable to reductions in force since such circumstances do not involve the filling of vacancies. Based on the statutory language and the legislative history, the court in Mescalero found that Congress did not intend the preference to be applied in a manner that would result in the displacement of existing non-Indian employees of BIA. Following the Tenth Circuit's decision in Mescalero, however, Congress enacted legislation making the preference applicable to reductions in force at BIA and the Indian Health Service. See 25 U.S.C. § 472a(a) (1982). "The purpose of this provision is to overcome the adverse effects of the Mescalero decision...." H.R. Rep. No. 370, 96th Cong., 1st Sess. 12, reprinted in 1979 U.S. Code Cong. & Ad. News 2068, 2077. See Preston v. Heckler, 734 F.2d 1359, 1371 n.15 (1984) (commenting on the Congressional response to Mescalero in a case involving application of the preference in the Indian Health Service).

In the Commission's view, Congress's use of the general term "employment practice" in Section 703(i) of Title VII suggests an intent to permit preferential treatment of Indians more broadly than in the context of hiring alone. Although the court cases discussed above analyze the scope of an Indian preference authorized under a statute other than Title VII, the Commission believes that these decisions and the subsequent Congressional enactment in response to them provide useful guidance in determining the breadth of the term "employment practice" in Section 703(i).

Drawing upon this guidance, it is the Commission's position that, for Title VII purposes, employment practices under which preferential treatment may be accorded to Indians are those requiring the selection of individuals to fill positions, however created, or to retain positions when jobs are eliminated. Accordingly, the preference is applicable to employment decisions involving, for example, hiring, promotion, transfer, and reinstatement as well as to layoffs and reductions in force.

The Commission does not reach a determination of whether the term "employment practice" in Section 703(i) covers other terms, conditions, or privileges of employment, such as compensation, benefits, work assignments, or training. The issue of whether the Indian preference in Title VII extends to employment decisions involving such terms and conditions is non-CDP. Charges raising this issue should be processed according to the instructions provided in EEOC Compliance Manual § 603 for processing priority-issue charges.

Tribal Affiliation

The final issue to be addressed is whether the extension of an employment preference based on tribal affiliation--that is, a preference limited to Indians who belong to a particular tribe, to the exclusion of members of any other tribe--is permissible under Section 703(i) of Title VII. The issue arises, for example, where an employer located on or near a specific Indian tribe's reservation wishes to accord a preference restricted to members of that tribe either on its own initiative or in compliance with a tribal ordinance requiring that a preference be given to members of the tribe.

The Indian preference exception provided in Section 703(i) is stated in general terms. That section neither expressly authorizes nor prohibits a distinction among Indians based on tribal membership. By contrast to Title VII, which is silent on the issue of tribal affiliation, regulations promulgated by the Office of Federal Contract Compliance Programs (OFCCP) of the Department of Labor and by the Department of the Interior specifically prohibit consideration of tribal affiliation in according the preferences permitted.

The relevant provision of the OFCCP regulations, which are applicable to federal contractors, is found at 41 C.F.R. § 60-1.5(a)(6) (1987). The first two sentences of that section are set out in the foregoing discussion of the definition of the phrase "on or near an Indian reservation." The final sentence of the section provides, in pertinent part, as follows:

> Contractors or subcontractors extending such a preference shall not, however, discriminate among Indians on the basis of religion, sex, or tribal affiliation ....

41 C.F.R. § 60-1.5(a)(6) (1987) (emphasis added).

Section 7(b) of the Indian Self-Determination and Education Assistance Act of 1975, 25 U.S.C. § 450e [illegible] requires the inclusion of Indian preference provisions in certain federal [illegible] and grants. Regulations issued by the Department of the Interior [illegible] governing the implementation of Section 7(b) of that Act, appear at 48 C.F.R. § 1424.7000 et seq. and §§ 1452.204-71 and 72 (1987). These regulations require the insertion of the following clause in specified contracts:

> The Contractor agrees to give preference to Indians who can perform the work required regardless of age (subject to existing laws and regulations), sex, religion, or tribal affiliation for training and employment opportunities under this contract and, to the extent feasible consistent with the efficient performance of this contract, training and employment preferences and opportunities shall be provided to Indians regardless of age (subject to existing laws and regulations), sex, religion, or tribal affiliation who are not fully qualified to perform under this contract.

48 C.F.R. § 1452.204-71 (1987) (emphasis added).

Thus, under the cited regulations of both OFCCP and the Department of the Interior, covered federal contractors may not discriminate among Indians on the basis of tribal affiliation in extending an employment preference. Although Title VII is silent in this regard, the Commission considers the prohibition expressed in those regulations to best serve the purpose intended by Section 703(i).

On this point, the Commission believes that, in enacting Section 703(i), Congress intended to encourage the extension of employment opportunities to Indians generally, without allowing discrimination among Indians of different

tribes. Under Section 703(i), the exception applies to employment practices under which preferential treatment is given to "any individual because he is an Indian living on or near a reservation" (emphasis added). The statutory language supports the conclusion that Congress did not intend to permit tribal distinctions among Indians otherwise qualifying for such preferential treatment.

Further, as a practical matter, the Commission notes that in some instances employers may be located on or near the reservation of only one tribe and that the Indians living on or near that reservation may be members of that tribe. Under such circumstances, the preference may operate, in effect, to favor only members of that specific tribe without disadvantaging Indians of other tribes. However, in some parts of the country employers are situated near the reservations of more than one tribe or more than one tribe may share the same reservation. The potential inequities resulting from according a preference based on tribal affiliation are most clearly evident when these circumstances are contemplated.

In light of these considerations, it is the Commission's position that extension of an employment preference on the basis of tribal affiliation is in conflict with and violates Section 703(i) of Title VII. The Commission emphasizes, however, that its position with respect to Section 703(i) affects only employers covered by Title VII. Since Indian tribes are exempt from the provisions of the Act under Section 701(b)(1), the preferences or requirements based on tribal membership or affiliation imposed by a tribe with respect to its own employment practices are not violative of Title VII. See Wardle v. Ute Indian Tribe, 623 F.2d 670, 23 EPD ¶ 31,035 (10th Cir. 1980).

DATE 5/16/88

APPROVED Clarence Thomas
Clarence Thomas
Chairman

Item 19

STATEMENT BY

THE

U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

The U.S. Department of Housing and Urban Development operates three major housing programs in the Indian community: the Lower-income Indian Housing Rental Program; and the Homeownership Opportunity Programs, which include Mutual Help (MH) and Turnkey III. Indian communities are also eligible to participate in Community Development Block Grant (CDBG) Program for Indian tribes and Alaska Native villages; and the Urban Development Action Grant (UDAG) Program. In addition, private sector sponsors can develop housing under the FHA mortgage insurance programs, such as the Section 231-Housing for the Elderly Program, and private non-profit sponsors are eligible to apply for Section 202 direct loans for development of projects for the elderly or handicapped in Indian communities. Other Section 8 programs, including but not limited to Vouchers, are available near reservations. Multifamily projects for the elderly were eligible to participate in the Congregate Housing Services demonstration and several made applications.

HUD's Indian Programs are administered through six Indian field offices, in Chicago, Oklahoma, Denver, Phoenix, Seattle, and Anchorage.

The Department's Indian programs for housing and community development are administered in the context of the special needs and circumstances imposed by Indian trust land restrictions, the diverse and complex historical and cultural patterns of Indian and Alaska Native life, and the special legal and historical relationships between the Federal Government and Indian tribes. The design of HUD's current Indian programs reflects a continuing effort to achieve delivery systems that are responsive to the special housing and community development requirements of Indian and Alaska Native communities.

The Department provides housing assistance for American Indians and Alaskan Natives, including elderly individuals and

families with elders in the household, pursuant to the United States Housing Act of 1937, as amended. Indian Housing Authorities (IHAs) operate rental and homeownership opportunity programs primarily on Indian lands. As of June 30, 1988, there were 176 IHAs operating more than 61,000 units, of which about 3,000, or 4.8%, house the elderly in specifically designated units.

HUD has proposed 1,000 new units in FY 1989. This is in addition to the 2,000 units to be reserved in FY 1988 and the almost 10,000 units in the Indian Housing pipeline. These additional units will meet 25% of the reported need. It should also be emphasized that since the early 80's HUD has provided 38% of all housing in Indian areas.

Nearly all of the units developed under the Indian housing programs are free standing, single family houses, and more than 60% of those are under lease-purchase contracts; for this reason, and because many of the units are built on land assigned or allocated to the resident families, families tend to remain in residence for long periods of time. As a result, homes originally occupied as family units ten or fifteen years ago are now occupied by elderly families. Recent occupancy surveys indicate that between 20% and 25% of the units under IHA management (about 12,000 units) are homes to elderly people or to families that include one or more elders.

With respect to the issue of need for additional new units specifically for the elderly, the Department's experience in this context is limited. We have historically based allocation decisions on the fact that the IHAs do not usually apply for centralized elderly apartment projects for the elderly in Indian communities. Our information suggests that this population generally has closer family structures than does the society in general, and that elders tend to remain with their grown children and their families, rather than seeking specialized housing environments for the aging generation(s).

The Department has implemented the statutory preference for large-family units reflected in successive appropriations acts. We do not know if IHAs are misunderstanding this "preference" as an absolute prohibition on elderly units, or if elderly demand is so small relative to family need that the IHAs do not feel elderly units are justified. Our experience tends to support the latter case. In the case of IHAs without a rental program, IHAs might not be able to address the needs of the elders, knowing that elderly individuals or couples would neither be eligible for 3 or 4BR Mutual Help units nor interested in a long term lease purchase arrangement.

In informal discussions with two of our field offices concerning this year's application cycle, we learned of requests for three rental projects specifically for elderly/handicapped. The total units requested for these projects is 46; they would be located in three different rural communities. Another IHA stated that there was definite need and interest in their territory, and that they have two communities where they would be interested in locating an elderly project.

There are examples of Indian housing targeted to the elderly in every Indian region. In the Midwest near Duluth, Minnesota, the Fond du Lac IHA is developing a 15-unit elderly multiplex, located near a medical clinic. The Chicksaw IHA recently built a high-rise complex in Ardmore, Oklahoma. The Laguna Rainbow Project in New Mexico consists of a 20-bed nursing home and a 40-unit congregate facility. Specialized services are provided to the projects' residents using funds from HUD's congregate service program.

In Anchorage, Alaska, the Cook Inlet Housing Authority has already developed two Congregate Elderly projects of 60 units funded about 60% by the State of Alaska and the rest through HUD's Indian housing program.

CONGREGATE SERVICES

There are five Congregate Housing Services Projects (CHSP),

Pueblo of Laguna Housing Authority in New Mexico
Northern Cheyenne Indian Housing Authority, Montana
Yankton Sioux Indian Housing Authority, South Dakota
Cherokee Housing Authority, Jay, Oklahoma
Cherokee Nation Section 202 project, Talequah, Oklahoma

Projects included in the CHSP demonstration were required to indicate that CHSP services were needed because services existing in the community were insufficient or inadequate to meet the needs of the elderly population.

SECTION 202

Our experience with Section 202 program indicates that the program is not feasible in many smaller Indian communities. The Indian housing experience shows that a project of less than 100 units is usually not economically feasible under the 202 program. Typically applications for Indian 202 projects are smaller than 100 units. It is also true that Indian Housing Authorities have experienced difficulty in attracting Indian elders to "elderly" projects; the Laguna Pueblo project, for example, has generally had a vacancy rate of 40 percent or more throughout its life.

Accordingly, the Department has not emphasized outreach to potential Indian Section 202 sponsors. However, individual field offices -- particularly in Greensboro and Oklahoma City -- have attempted to circulate program information to Indian communities and to encourage development of approvable applications in recognition of special, local circumstances.

In addition, it must be stated that the Section 202 program operates on a note-and-mortgage principle, and that the issue of loan security is as central to Section 202 lending as it is to any other mortgage. Therefore, in proposing a Section 202 project, Indian communities face the familiar question of land inalienability, with the predictable limitations on the security of the loan.

Item 20

DEPARTMENT OF HEALTH & HUMAN SERVICES

Additional Copy

Memorandum

Date July 7, 1988

From Clinical Director
Rapid City Service Unit

Subject Third Party Payments

To Dr. Everett Rhoades
Director
Indian Health Service
THRU: Terrence W. Sloan, M.D.
Director
Aberdeen Area IHS

As IHS physicians, we are dedicated to the improvement of health care for our patients and the Indian community. Often, we feel that our hands are tied with bureaucratic rules and red tape in providing this care. I specifically refer to current laws, mandates and regulations preventing us from collecting third party payments. Funding for the Indian Health Service has always been tight but the added dollars from third party payments can make a difference in Service Unit budgets, staffing, equipment and health care. Clearly, to the clinicians providing medical care to the patient, generating health care funds should be considered IHS's second priority. I have found five areas in which legislation could significantly improve our present budget crisis.

1. Currently, IHS physicians providing care in private hospitals are unable to generate bills to Medicare or Medicaid. The hospital bills are paid but we cannot collect for physician fees if the services are rendered in a non-Public Health facility. Sioux San Hospital in Rapid City, South Dakota, is losing thousands of dollars from GYN surgeries, Ceserean Sections and vaginal deliveries performed by our physicians at Rapid City Regional Hospital. Almost 50% of our OB/GYN work is for Title 19 eligible patients. Collection of these dollars could provide funds to hire an additional OB/GYN for our hospital. IHS physicians providing care at private institutions appears to me to parallel Mr. Reagan's desire for privitization of the IHS. As this privitization spreads throughout the IHS, this problem can only become worse.

2. Medicare and Medicaid eligible patients who are admitted to the hospital for less than 24 hours are being forced to be billed as outpatient procedures or else be denied by the Professional Review Organization for inpatient billing. Therefore, a tubal ligation performed at Pine Ridge, including anesthesia, can only be billed for the $66.00 outpatient charge. A chronic admission for a four unit blood transfusion can also only be billed for $66.00. Private hospitals have found inroads around this problem by "itemized billing", a process that the Public Health Service is denied. It doesn't appear fair that private hospitals can generate income by billing each item (i.e., anesthesia, blood banking, laboratory, etc.) separately and the IHS should settle for a $66.00 outpatient fee. Significant dollars are lost on many costly outpatient procedures such as day surgery, endoscopy, chemotherapy, transfusions, and IV hydration, to name a few.

3. I understand that for many years, the discussion as to the IHS billing private insurance has existed. Many of our patients, including our Indian hospital staff, have good paying insurance. If the IHS is the "Agency of Last Payment", then insurance companies should be billed for services rendered. The dollars should then be returned to the Service Unit, not placed in a general trust fund as is the present situation.

4. Frequently, IHS hospital beds are filled with social admissions or patients needing nursing home placement. We are unable to bill Medicare or Medicaid because intensity of medical service requirements are not met on these patients. Thus, much labor and intenstive nursing and other hospital services are not being reimbursed. Apparently, the IHS is unable to bill M/M for "swing" beds because they are not considered acute care. In private institutions, "swing beds" are billed but at a lower rate than medical necessity beds. This allows some compensation for the expenditures.

5. The Indian Health Service should consider the development of several strategically-located IHS or Tribal Nursing Homes. M/M dollars could be billed to those patients who were eligible. A more culturally sensitive atmostphere could be provided to our elderly population, a condition which is very important to our patients. Adequate Nursing Homes would reduce the number of hospital admissions of those patients who refuse to go to a white Nursing Home but are extremely comfortable in staying in the hospital with other elderly patients. These patients are receiving poor care, even neglect and abuse, in their present home situations and are admitted to the hospital once they are extremely ill or dying. I feel that a subtle cost savings in addition to the improvement of elderly health care would be of benefit to the IHS.

As a member of the National Council of Clinical Directors, I have forwarded these suggestions to Dr. Chuck North, Chairman of the NCCD, for discussing at the next NCCD Meeting in November of this year. It is my hope that the NCCD will pass resolutions towards Headquarters in working on these items. I hope that you will support our efforts on these items. Please forward copies of this letter to those Headquarters personnel involved in these areas.

Thank you for your time, consideration and continued support of the physicians in the field.

Sincerely,

Allen W. Jones, Jr., M.D.

Item 21

STATEMENT OF THE BUREAU OF INDIAN AFFAIRS, DEPARTMENT OF THE INTERIOR BEFORE THE HEARING OF THE SPECIAL COMMITTEE ON AGING OF THE U.S. SENATE IN PINE RIDGE, S. D. ON "AMERICAN INDIAN ELDERLY-THE FORGOTTEN POPULATION".

JULY 21, 1988

The Bureau of Indian Affairs is pleased to respond to the Committee's request for a statement for the record of the subject hearing.

Social services provided by the BIA are the services that are not available from other Federal, State or locally funded programs. The BIA, in most cases, provides interim assistance until the Indian elderly can qualify for either Federal or state programs. As a result the majority of Indian elders are served by various programs authorized under the Social Security Act such as Supplemental Security Income (SSI), Medicare, and Title VI of the Older Americans Act. Recipients of aid from Title VI must be 60 years of age and those receiving SSI must be 65 years of age if age is the only factor being considered. Other services include general assistance, custodial care, and Individual Indian Money (IIM) account supervision.

The BIA also provides assistance in the management of interests elders may have in land held in trust by the BIA. Other assistance given the Indian elderly relates to the preparation of wills and assistance in the preparation of conveyance documents. Advice is also provided to those owners who wish to deed their land to a relative and retain a life estate.

The BIA operates a Housing Improvement Program (HIP) which involves repair and renovation of Indian housing and the construction of some new homes. This program is aimed at improving the standard of housing for those people who are not qualified to receive housing assistance from any other source. The HIP program has a ranking system based on need. Although the program by design is not specifically for the Indian elderly, a majority of the elderly qualify as HIP recipients based on need.

Programs for the Indian elderly vary a great deal in different BIA Areas. For the most part, the tribes provide the most comprehensive programs that are available. They are able to do this through cooperation with the above mentioned Federal programs. Referrals usually come from the Indian Health Service centers. The centers often assist with applications and guide the elderly to the program for which they qualify. The BIA does respond to special needs that could not be met otherwise.

On a number of reservations in South Dakota, BIA social services staff serve on local committees which focus on the needs of tribal elders. The Indian population in the BIA's Aberdeen Area includes 6,130 elderly individuals, 95 percent of whom reside on reservations. The elderly represent 9.2 percent of the Area's total service population.

The Wind River Reservation tribes of Arapahoe and Shoshone in Wyoming have a nursing home called Morning Star Manor. The tribe supplements individuals' Social Security income to defray the total cost of care at Morning Star Manor. The cost per individual is $1900 per month. They serve 37 full-time live-in elderly. The tribes contract the operation to professionals with the plan of training tribal people to eventually take over the full time operation.

In addition to this facility, there are four Senior Citizen centers on the reservation. Two serve the Shoshone Tribe and two serve the Arapahoe Tribe. Each day, 48 noon meals funded by Title VI are served to those 60 years and over. Twenty-four meals are delivered to homes each day. The centers also provide transportation for the elderly to enable them to take care of personal and medical needs.

The BIA General Assistance program serves low income members of the community who are 55 years of age and a few handicapped individuals. Last year the Shosnone Tribe contributed $20,000.00 to the program and also paid out $28,000 to help with heating bills. The members who are eligible for SSI receive $354 per month. It is estimated that there are approximately 400 Arapahoe and 200 Shoshone who are 60 years of age and older.

The Phoenix Area and Navajo Area in the state of Arizona have an unusual situation because Social Security has denied SSI service to Indian people who are placed in facilities where the BIA pays for the balance of their care. Arizona never had the Medicaid program and the counties have never approved Indian people as clients for assistance programs. In the absence of assistance from the State, the BIA has developed a program for adult care. Six or seven group homes are operated which are similar to nursing homes. These are contracted by the tribes and are BIA funded. The homes serve 350 elderly beginning at 55 years of age. The tribes also operate Senior Citizen centers under Title VI and Title III of the Older Americans Act. They serve meals at the centers and deliver some meals to homes, The problem of distances and lack of vehicles prohibit them from providing more delivered meals.

It should be noted that our FY 1989 budget proposes to phase out our aid for institutional care in Arizona as the State phased in its program for Indians and nonIndians. Although the House Appropriations Committee accepted that proposal, the Senate Appropriations Committee has directed that we continue providing for those costs in Arizona as in the past.

Several issues that have a negative impact on the Indian elders have been identified by the local committees in South Dakota and include the following:

Contrary to popular belief, tribal elders are not always accorded high status in their communities. Concomitantly, there is limited awareness of their needs and of their overall importance to the culture. It is believed that Indian tribes, as well as agencies which serve reservation populations, could counteract elders' loss of status and respect by emphasizing their needs and designing programs to meet those needs.

In most communities there is no advocacy for the Indian aged. Tribes and service agencies should be encouraged to hire specialists to advocate for the aged population regarding a variety of issues, including the need for social stimulation of this highly isolated group.

Transportation costs are excessive for the Indian elderly. On most reservations, the elderly rely on private individuals for transportation (including family members) who may charge for transporting them to medical facilities, church, and even to visit their families. Transportation difficulties is the most universal issue with the Indian elderly.

Telephone service is generally too expensive in rural reservation communities, and is therefore beyond the financial capabilities of the Indian elderly who vitally need telephones.

The Department of Housing and Urban Development (HUD) and tribal housing authorities should reevaluate housing rent structures for the elderly, because rental costs are often disproportionally high for the incomes of most Indian elderly.

Although some tribal interests oppose out-of-home care for the elderly, others strongly believe that the development of reservation based nursing home facilities should be given high priority.

Presently, homemaker/housekeeper services are available on a limited basis from the State of South Dakota and, marginally, from the BIA. It is our understanding that the State of South Dakota's funding for homemaker/services is sometimes exhausted prior to the end of the fiscal year. At this time BIA attempts to provide a minimal program to finish the year to prevent undue hardship on those who are dependent on this service.

Due primarily to the extraordinarily high incidence of diabetes among the Indian elderly, much emphasis should be placed on nutrition education programs and on the importance of the proper use of medications.

Reliable statistics on Indian elder abuse do not exist. Social Service professionals express the consensus that, in the majority of cases, abuse is from within the family and is usually well hidden. It is suspected that a high percentage of elder abuse is perpetrated by family members who seek to extract money from either IIM accounts or from the small monthly income that most elderly receive. It has been recommended that Indian elder abuse be identified as a public health issue, and that greater emphasis be placed on reporting and on generating a greater awareness of the problem.

According to the 1980 Census, the average life expectancy for the Indian population is eight years shorter than that of the rest of the population. Studies by the National Indian Council on Aging show that the Indian elderly live in poor housing and poor health. Federal programs that are established to provide health care to the Indian population indicate problems regarding the accessibility and utilization of these programs. The lack of transportation is a barrier to the services and facilities that do exist.

This concludes the statement of the Bureau of Indian Affairs.

Item 22

NATIONAL INDIAN HEALTH BOARD
50 South Steele Street, Suite 500
Denver, Colorado 80209
(303) 394-3500

August 10, 1988

The Honorable Larry Pressler
United States Senate
Washington, D.C. 20510

Dear Senator Pressler:

Enclosed please find the National Indian Health Board's response to your invitation to respond to current issues facing our American Indian/Alaska Native elderly. Thirty-five recommendations targeted toward improving health care conditions of the Indian elderly are incorporated in this statement.

Thank for your efforts to improve the plight of our nation's Indian elderly and for this opportunity to respond. Should you have any further questions or responses, please call or write.

Sincerely,

Jake L. Whitecrow

Jake L. Whitecrow
Executive Director

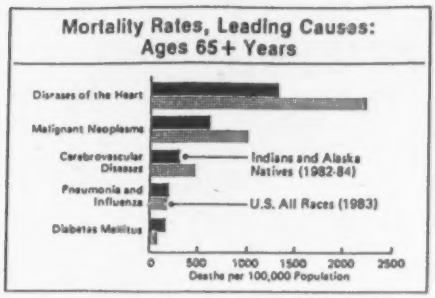

CHART 4.5

The two leading causes of death for American Indians and Alaska Natives, age 65 and over (1982-1984) were diseases of the heart and malignant neoplasms. For the U.S. All Races (1983), they were also diseases of the heart and malignant neoplasms.

TABLE 4.5

TEN LEADING CAUSES OF DEATH FOR DECEDENTS 65 YEARS OLD AND OLDER
American Indians and Alaska Natives in Reservation States, 1982-1984
Comparable U.S. All Races Rates, 1983
Mortality Rates per 100,000 Population

Cause of Death	American Indians and Alaska Natives Number	American Indians and Alaska Natives Mortality Rate	U.S. All Races Mortality Rate	Ratio: Indian to U.S. All Races
Total 65 Years +	8,084	3,765.7	5,113.8	0.7
Diseases of heart	2,852	1,328.5	2,231.0	0.6
Malignant neoplasms	1,329	619.1	1,029.8	0.6
Cerebrovascular diseases	672	313.0	487.7	0.6
Pneumonia and influenza	417	194.2	174.0	1.1
Diabetes mellitus	357	166.3	96.2	1.7
Accidents	311	144.9	86.8	1.7
Motor vehicle	103	48.0	20.6	2.3
Other accidents	208	96.9	66.3	1.5
Chronic obstructive pulmonary diseases and allied conditions	230	107.1	192.6	0.6
Nephritis, nephrotic syndrome and nephrosis	166	77.3	55.6	1.4
Chronic liver disease and cirrhosis	121	56.4	34.5	1.6
Atherosclerosis	101	47.0	91.3	0.5
All other causes	1,528			

NOTE: Connecticut, Rhode Island and Texas included as reservation states beginning in 1983, and Alabama in 1984.

Source: Indian Health Service Chart Series Book, April, 1987

Written Testimony Prepared for the Senate Special Committee on Aging to augment those statements presented before the field hearing "The American Indian Elderly: The Forgotten Population". Following is NIHB's response to questions posed by Senator Larry Pressler.

I. What is the health status of the Indian elderly compared to other groups?

According to the Indian Health Service (IHS) the ten leading causes of death for descendants 65 years old and older for American Indians and Alaska Natives in Reservation States, 1982-1984 (please see next page for comparative data) are as follows: 1. Diseases of heart; 2. Malignant neoplasms; 3. Cerebrovascular diseases; 4. Pneumonia and Influenza; 5. Diabetes mellitus; 6. Accidents; 7. Chronic obstructive pulmonary diseases and allied conditions; 8. Nephritis, nephrotic syndrome and nephrosis; 9. Chronic liver disease and cirrhosis; and 10. Atherosclerosis.

The National Indian Council on Aging (NICOA), has provided insights shared by past conference participants. An undisputed finding is that one indicator of the poor health encountered by Indians is their lower life expectancy, which is approximately 10 years lower than the rest of the population (65 yr. vs 73 years in 1980). A number of diseases, such as tuberculosis and diabetes, are much more prevalent among Indian elders than among the non-Indian elderly. A recent national study conducted by NICOA found that the rate of tuberculosis is five times higher among the Indian elderly than among the non-Indian elderly. There is also an exceptionally high rate of adult-onset diabetes. On one reservation, 40% of all adults have diabetes.

Obesity is a health problem that increases the severity of certain diseases and has been identified as a catalyst of other health problems, such as heart disease and diabetes.

In the area of mental health, elderly Indians, if they have any mental problems, are likely to suffer from some type of neurosis, such as anxiety or depression. As it is with the non-Indian elderly, the total number receiving mental health services in proportion to their population is low.

II. What type of health care services are available or not available to these individuals?

Elderly Indians are subject to the same restraints imposed on other segments of the Indian population; this is particularly true for those residing within the Indian Health Service delivery system. IHS does not have the financial resources necessary to fund 100% of the level of need; the latest estimations place the

figure at 89%. Even so, this is conservative at best, since supporting documentation is lacking for mental health needs; and there is an ever growing alarm over elder abuse. IHS does not have programs with a comprehensive response to address this issue, other than medical attention. Much more is needed--starting with an assessment of the frequency and severity of abuses to the elderly. Communities need to be included in the treatment approaches.

Services available to those Indians residing outside the IHS service area, is very limited. As a result, very few elderly Indians in the city seek out health care, either because the cost of modern urban health care is too exorbitant or because the surroundings are too foreign. The National Indian Council on Aging, (NICOA) has found that preventive care and dental treatment are very rarely sought. Many of the elderly are unemployed and consequently uninsured. The rising costs of insurance rates, places this basic need out of reach for many of our nation's Indian elders. All of this contributes to our elders going without medical care, with the exception of emergencies. This reality in all probability, costs us many lives that could have been prolonged with proper medical attention. Indian elders, among others, need to be able to access medical services when needed. When urban Indians do seek out health services, some may be refused services from public agencies because of the common misconception that IHS and BIA will meet their needs.

For the rural and reservation elders who are served by IHS other problems arise in spite of IHS's significant efforts and contributions. Lack of transportation continues to be a major dilemma for elders.

More home health aides and CHRs for the Indian elderly are needed for such services as assistance with responding to minor medical problems; bathing, toileting and other types of hygiene; dispension of medicine; and sanitation measures.

Indian people have long prided themselves on taking care of their elders. Recent public attention has brought to the forefront a much more painful concept that some of our elders are

not only not being held in reverie but are being assaulted as well. IHS needs to record such matters that come to their attention, better enabling preventive and treatment programs to respond. Cooperation with the police, social services and other agencies to streamline efforts would also prove beneficial.

III. How is the physician and nurse shortage impacting the quality of care provided to the elderly Indian?

According to the Office on Technology Assessment's (OTA) report on Indian Health Care in 1985, IHS estimated its unmet need for health professionals relative to workloads in terms of unfilled positions, using an application of the resource requirement methodology. In 1985, unfilled staff positions in IHS facilities and tribally operated health programs were estimated to exceed 1,500 health professionals, including 155 surgeons (among other types of physicians) and 697 nurses. The ramifications of this scenario are obvious--would-be patients, including the elderly, are put on hold and left unserved, in favor of those deemed to be of a higher priority. Difficulties in recruiting and retaining medical staff limit the types of services available at many IHS hospitals, and surgeons are particulary difficult to recruit, in part because there are no National Health Service Corps (NHSC) scholarships for surgeons. The following are among the services not provided in any IHS hospital, according to the 1983 American Hospital Association Annual Survey of Hospitals: cardiac catheterization, X-ray radiation therapy and other megavoltage and radio-isotope therapeutic services, organ transplantation, burn care, and neonatal intensive care. Only nine (out of 47) IHS hospitals have a separate mixed intensive care unit, four operate premature nurseries, and three provide hospital-based renal dialysis. Conversely, 32 of 51 IHS and tribally operated hospitals have obstetrical services and 42 offer dental services. Although outpatient psychiatric and alcoholism services are widespread, there is only one inpatient alcoholism service and there are five inpatient psychiatric units . In part because IHS direct inpatient services are relatively limited even where hospitals are accessible, the IHS contract care programs has been under increasing budgetary pressures in recent years to fill these service gaps.

As stated in previous point, the shortage of nurses, including home health aides and CHRs has negatively impacted the services available to the elderly.

IV. Do the elderly Indians seek health care among non-professionals?

While it is generally agreed, Indians, including some of the elderly, do seek out and utilize the expertise among traditional healers or medicine men, it is not possible to document this belief with any convincing data. It is also known, that some Indians, have employed the use of both their traditional medicine and Western medicine, depending on the nature and severity of the malady. Factors which influence the choice of resources, include among other things, how commonly practiced and accepted traditional medicine is within the specific community. A very rough estimation places the use of traditional healers between 5 (five) and 10 (ten) percent. There has been some resurgence of Indian people going back to the old ways in finding meaning to their life; and with this pursuit came a desire to learn and apply their ancestors beliefs.

V. What problems can you identify in the current health care delivery system that reduces the quality of care?

Tribal leaders and/or the elders need to be a viable force with meaningful input into the formulation of policies, prior to their development. In fact, tribal health consumers need to be involved in all aspects of health care which impacts their health and survival. To exclude their participation reduces the level of quality attainable by overlooking valuable and necessary sources.

Alcoholism is the number one killer of Indian people, yet only one percent of the total IHS budget is directly allocated toward its prevention and treatment. It is a gross understatement to say more needs to be done. It is imperative that tribal people are involved and participants in the approach selected.

Family violence continues to make headlines daily in tribal and community newspapers, yet only recently has IHS focused attention on this matter. Elderly abuse can no longer be ignored or viewed as the family's problem and responsibility. IHS needs to take an active role in first assessing the magnitude of this

type of violence and other assaults that occur to all age groups of the Indian population. NIHB has been encouraged by some recent headway made in this area. NIHB congregated a small group of Indian people, whose background included extensive experience related to family violence programs. Through this effort, contacts were made with the IHS Special Initiatives Team, the American Indian Law Center, Victim Services Agency, Bureau of Indian Affairs and others who sent representatives to meet in how to proceed to address this problem. A task force developed with IHS assuming major responsibility for spearheading this effort.

It seems appropriate to respond to this question with a list of recommendations developed by the National Indian Council on Aging (NICOA) conference participants in 1985 and more recently by the elders attending the National Training and Program Development conference on substance abuse and destructive behavior August 2-5, 1988:

* Programs and services to combat elder abuse need to be developed and implemented.
* Alcohol and substance abuse programs need to be adapted to specifically recruit and help elders and their families with the problems that occur with addictions.
* Elders are in need of advocacy efforts in their best interests. Comments have been made that elders are being "warehoused" and shoved into places--places not desired, such as nursing homes.
* Attention needs to be given to the problem of medical equipment, such as wheel chairs, walkers, hospital beds, glasses, prostheses, etc., for which there is never enough funding or thought given to replacement problems.
* More senior Indian centers need to be established where elderly can meet, have meals, games, activities, and companionship.
* Title III programs need more volunteers.
* The younger generation of Indians need to become stronger advocates for services to the elderly.
* More funds need to be made available for home health demonstration grants to allow tribes to establish these vital programs.
* In-home services need to be increased. Again, more funds need to be made available to tribes for these services.
* More homemakers should be provided for under Title VI of the Older Americans Act.

* Members of the some tribes, such as the Navajo often live apart from each other and from services. They need better health services in the homes.
* The age limit for in-home and other related services needs to be lowered in order to serve more of the needy elderly.
* There needs to be more coordination between the agencies working in the home health care field and related services.
* Transportation funds and services need to be increased to allow for greater service delivery - outreach, CHR, home health.
* In some areas (notably the Navajo area) interpreters are needed in conjunction with transportation services when monolingual elderly have errands, appointments, etc. during which they have to interact with others who don't know their language.
* Interpreters should be hired to work with elders as out-reach workers or Information and Referral Technicians. Funding should be made available for this.
* Every community needs an information and referral service for health services for the chronically ill. Planning, training and research for the community could come from this central source.
* Better basic information on all titles and programs should be provided so that everyone can understand how and why the services are provided.
* A system to develop more program awareness needs to be devised: how to get benefits; where to get benefits; what program titles are available to the elderly, etc.
* Workshops for tribal elders on the use of Medicaid and Medicare should be provided; better use of these services could thus be accomplished.
* Assistance needs to be provided to the elderly in applying for SSI, food stamps, etc.
* Food Stamp regulations should be made more flexible. Direct funding to reservation programs should be made available.
* More emphasis needs to be placed on training elders to advocate at the local, state and national levels for their own programs.
* Individuals performing services of the elderly need to educate themselves better in performing their duties.
* Tribal program administrators need training to make them aware of the tribal elderly who will come under their programs, and

also of what funds and programs are available.

* More training funds need to be allocated to train people to work with Indian elderly.

* In general, more funds are needed for work with the elderly, and more people need to be trained for this work.

* The Federal government needs to be educated that even though some of the tribes have small population counts that the need for vital services is still great. There should not be a minimum population required for eligibility for grants.

* More funds need to be allocated, over-all for Indian aging programs.

* Tribes should be able to determine their own needs and service delivery concepts - i.e., direct funding. Title VI programs should be written so as to be more understandable to Indians and less bureaucratically phrased.

* More tribes should apply for and utilize Title VI, direct funding. The Federal government needs to allocate more funds for various direct funding programs.

* There needs to be increased coordination at the state (county) and Federal levels with tribal aging programs.

* Plans need to be developed to deal with the BIA to make it more supportive of elderly needs.

* The Office Of Native American Affairs, mandated by Older Americans Act (OAA) Amendments of 1987 should be administered by an American Indian/Alaska Native with extensive experience working with tribal elder programs.

* As Congress reconsiders the impact on the final rule on eligibility special attention should be given to the needs of Indian elders who may not meet the revised eligibility criteria, but nevertheless rely on IHS as their principle source for health care. Consideration should be given to exempting Indian elders from any changes in IHS eligibility regulations.

As a final note, attached to this statement are copies of resolutions passed by the NIHB Board of Directors incorporating area caucus positions submitted during the Ninth National Indian/Alaska Native Health Conference in Seattle, WA, September 9-12, 1987.

NATIONAL INDIAN HEALTH BOARD
50 South Steele Street, Suite 500
Denver, Colorado 80209
(303) 394-3500

RESOLUTION
OF THE
NATIONAL INDIAN HEALTH BOARD

Resolution 88-03

INDIAN DESK - ADMINISTRATION ON AGING

WHEREAS, the Administration on Aging includes within its administrative structure an Indian desk that is filled by a non-Indian employee; and,

WHEREAS, the National Indian Health Board remains strongly in favor of Indian self-determination and Indian preference in all key positions in federal agencies responsible for providing services to Indian people,and

WHEREAS, the National Indian Health Board believes that these positions should be filled by Indians selected through consultation with affected tribes,

NOW THEREFORE BE IT RESOLVED that the National Indian Health Board calls for the Indian desk at the Administration on Aging to be filled at the earliest opportunity with a qualified Indian selected in consultation with tribal representatives appointed for that purpose.

CERTIFICATION

It is hereby certified that at the National Indian Health Board's Consumer Assembly Meeting held in Washington D.C., February 16-18, 1988 the foregoing resolution was presented and approved by a majority of the National Indian Health Board of Directors present.

Melvin R. Sampson, Chairman

NATIONAL INDIAN HEALTH BOARD
50 South Steele Street, Suite 500
Denver, Colorado 80209
(303) 394-3500

RESOLUTION
OF THE
NATIONAL INDIAN HEALTH BOARD

Resolution 88-14

ELDER ABUSE

WHEREAS, Native American Indian elders are a vital part of tribal life, customs and heritage; and

WHEREAS, Care and protection of Indian elders is of a special need; and

WHEREAS, A need exists to promote awareness and treatment of elderly abuse among our Indian population; and

WHEREAS, A need exists for development of networking systems and model programs to impact elderly abuse.

NOW THEREFORE BE IT RESOLVED, that the National Indian Health Board requests:

1. The Indian Health Service, in conjunction with other programs and agencies that impact the Indian elderly, enter into memorandum of agreements for identification and networking of systems and programs for prevention and treatment of Indian elderly abuse.

2. The Indian Health Service identify and request adequate funding for grants that will have significant impact on Indian elderly abuse.

3. The Indian Health Service declare a national policy for all Service Unit Areas to place greater emphasis and cooperation with tribal governments and tribal organizations to impact prevention and treatment of Indian elderly abuse.

4. The Indian Health Service immediately institute an informational and data gathering policy to identify to the greatest extent possible Indian elderly abuse.

5. The Indian Health Service adequately consult with all tribal governments the process by which it will institute to deal with the problem of Indian elderly abuse.

CERTIFICATION

It is hereby certified that at the National Indian Health Board's Consumer Assembly Meeting held in Washington D.C., February 16-18, 1988 the foregoing resolution was presented and approved by a majority of the National Indian Health Board of Directors present.

Melvin R. Sampson, Chairman

NATIONAL INDIAN HEALTH BOARD
50 South Steele Street, Suite 500
Denver, Colorado 80209
(303) 394-3500

RESOLUTION
OF THE
NATIONAL INDIAN HEALTH BOARD

Resolution 88-17

MENTAL HEALTH

WHEREAS, social disorders and dysfunctional families are prevalent throughout the United States, including Indian country; and

WHEREAS, violent crimes occur more frequently to residents living on reservations; and

WHEREAS, the Indian Health Service and the Bureau of Indian Affairs share the responsibility of providing health care prevention, intervention, treatment and care of Native Americans; and

WHEREAS, mental health programs must be culturally relevant with tribal input in order to be effective and meaningful; and

WHEREAS, adequate services are lacking within both federal agencies to assist these victims and their potential resources in terms of support teams, intervention, treatment and training, including tribal judicial and law enforcement systems.

NOW THEREFORE BE IT RESOLVED that the National Indian Health Board urges Congress to provide funding for the necessary services, integrating tribal specific needs of that community and approaches to address all segments of the population, youth, adult and the elderly.

BE IT FURTHER RESOLVED, that the National Indian Health Board requests the Indian Health Service to actively address the issue of Indian victimization, developing strategies to combat this reality in concert with Indian leadership.

CERTIFICATION

It is hereby certified that at the National Indian Health Board's Consumer Assembly Meeting held in Washington D.C., February 16-18, 1988 the foregoing resolution was presented and approved by a majority of the National Indian Health Board of Directors present.

Melvin R. Sampson, Chairman